PHEP OPERATIONAL READINESS REVIEW INTERIM GUIDANCE

March 2021

Public Health Emergency Preparedness (PHEP) Cooperative Agreement

Budget Period 3: July 1, 2021 – June 30, 2022

Centers for Disease Control and Prevention
Center for Preparedness and Response

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Introduction

The Centers for Disease Control and Prevention (CDC), Center for Preparedness and Response (CPR), Division of State and Local Readiness (DSLR) administers the Public Health Emergency Preparedness (PHEP) cooperative agreement program. The PHEP program helps build and strengthen public health systems that are ready to respond to and recover from public health emergencies. CDC's Operational Readiness Review (ORR) is a rigorous, evidence-based assessment used to evaluate PHEP program planning and operational functions. The overall evaluation strategy is guided by the Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health, which CDC released in 2018 and updated in 2019.

The ORR evaluation is intended to identify strengths and challenges facing preparedness programs as well as recognize areas for improvement and technical assistance. All 62 PHEP recipients and local planning jurisdictions with Cities Readiness Initiative (CRI) funding are required to participate in the ORR process. State recipients are not only responsible for ensuring statewide planning and operational function via the ORR but are also responsible for monitoring, tracking, and conducting local ORRs within their state. States may, at their discretion, review other local planning jurisdictions. See the Jurisdictional Structure Sheet (JSS) for instructions on how to include other local jurisdictions.

CDC encourages PHEP recipients and CRI-funded local planning jurisdictions to use the ORR to demonstrate that 1) risk assessments guide preparedness planning, 2) risk-based, all-hazards emergency plans are maintained, and 3) trainings, drills, and exercises are conducted on a timely basis.

The operational readiness review is not intended to replace other review processes, either at the state or local level. Partial ORR credit is granted for jurisdictions with valid accreditation from the Public Health Accreditation Board (PHAB) or from Project Public Health Ready (PPHR) recognition.

> PHAB: Current accreditation exempts recipients from review of planning measures for Capability 13: Public Health Surveillance and Epidemiological Investigation with relevant ORR credit applied for those measures. States have the option to exempt local planning jurisdictions with current PHAB accreditation from Capability 13 review.
>
> PPHR: This is a criteria-based training and recognition program created by the National Association of County and City Health Officials (NACCHO) and the CDC to help local health departments (LHDs) develop core public health preparedness competencies. This intensive 18-month program provides LHDs with the structure to build training and preparedness capacity using a continuous quality improvement model. Local planning jurisdictions with current PPHR recognition may be exempt from Section 2: Evaluation of Plans (capability planning elements) of the ORR. States will designate any local exemptions as applicable. The JSS form provides more detail.

Section 1: Jurisdictional Descriptive and Demographic Information

Section Organization

The ORR is organized into three sections: 1) descriptive and demographic, 2) planning, and 3) operations. Section 1 provides guidance about reporting and evaluating descriptive information for the jurisdiction and is organized as described below.

The dark blue tables provide information about the specific element, pertinent detail on what is required for data entry, and why it is important. The light blue tables describe how the reviewer will evaluate the information and when updates are required (submission frequency). Whether responsible for data entry or review, jurisdictions should read both tables to fully understand the ORR guidelines.

Element	Data Entry Guidance	Significance
Standardized nomenclature is used to label each measure. Elements and sub-elements are uniquely labeled using the three-letter acronym of the form. • Jurisdictional Structure Sheet (JSS) • Jurisdictional Data Sheet (JDS) • Partner Planning Sheet (PPS) • Workforce Development and Training (WDT) For example, "JSS2.a" refers to the Jurisdictional Structure Sheet, element 2, sub-element a. Note. The Critical Contact Sheet (CCS) collects contact information (name, phone, address, and email) about key staff and is not numbered since reference can easily be made to the person or position title.	Data entry guidance provides detail and clarifies expectations about what is measured.	The implication of the element is described.

Reviewer Guidance	Required Documentation	Submission frequency
Reviewer guidance provides detail and clarifies expectations about content components the reviewer must identify to deem the information acceptable as sufficient evidence.	Required documentation provides examples about the type of information recipients can submit as evidence to substantiate responses to elements. The examples of required documentation are not exhaustive. Evidence must include a creation or revision date that is in the acceptable range for a given element's submission frequency (annual, three years, or five years). Draft documents, such as updates to plans or after-action-reports (AARs), are acceptable with written acknowledgement by the PHEP director, or proxy, that the evidence is valid and used to support the PHEP program. Draft plans that do not meet the criteria will be adjudicated by the reviewer as **insufficient evidence** in the ORR.	Submission frequency details when ORR data must be submitted for documentation and validation. **Review** means the data entered should be re-examined for accuracy. **Update** means any data that is no longer accurate should be edited. **Validate** means that supporting evidence must be routinely maintained and documents must have dates within the required range.

Jurisdictional Structure Sheet (JSS)

Definition

The primary purpose of the JSS is to confirm the organizational configuration the state maintains for preparedness planning and evaluation. Preparedness directors or their proxies must complete and submit the JSS before any local ORRs can begin. Only states complete this information.

Element	Data Entry Guidance	Significance
JSS1 *ORR evaluation of Public Health Emergency Preparedness and Response Capabilities include* (Select relevant capabilities 1–15 for each local planning jurisdiction.)	Review the structure of local planning jurisdictions. States must review all local jurisdiction receiving CRI funding and those previously identified as planning partners. However, states are required to determine what planning capabilities are evaluated at the local level. See Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health. States must demonstrate local jurisdictional coverage for all capabilities exempted from local review. Additionally, states can choose to evaluate additional local jurisdictions.	Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health describes the components necessary to advance jurisdictional public health preparedness and response capacity. The capability standards serve as a state, local, tribal, and territorial resource to assess, build, and sustain preparedness and response capacity.

Reviewer Guidance	Required Documentation	Submission Frequency
Review information for accuracy and completeness. Ensure it is understood that states must substantiate oversight of any exempted local capability during the state ORR.	Submit the JSS, no supporting documentation is required.	Review annually and update as necessary.

Element	Data Entry Guidance	Significance
JSS2.a-b *Accreditation* *a. Public Health Accreditation Board (PHAB)* *b. Project Public Health Ready (PPHR)*	Review expiration date for accreditation and upload corresponding accreditation certificate (or equivalent evidence). Accreditation evidence indicates a jurisdiction's interest in waiving applicable components of the ORR.	PHAB is a national public health accreditation program that demonstrates a health department's commitment to quality improvement, performance management, accountability, transparency, and the capacity to deliver the 10 Essential Public Health Services. The accreditation process focuses on general public health surveillance and epidemiological investigation and parallels Capability 13 review in the ORR; thus, PHAB accreditation qualifies for limited exemption from components of the ORR review process. PPHR is a criteria-based training and recognition program created by NACCHO and CDC to help LHDs develop core public health preparedness competencies. This intensive 18-month program provides LHDs with the structure to build training and preparedness capacity using a continuous quality improvement model. Local planning jurisdictions with current PPHR recognition may be exempt from Section 2: Evaluation of Plans (capability planning elements) of the ORR. States will designate any local exemptions as applicable.

Reviewer Guidance	Required Documentation	Submission Frequency
JSS2.a Review accreditation documentation. If current PHAB accreditation is substantiated, Capability 13, Public Health Surveillance and Epidemiological Investigation is exempt from ORR. **JSS2.b** Review accreditation documentation. If current PPHR recognition is substantiated, states have the option of waiving any of the 15 planning capabilities in the local ORR.	Submit documentation of current PHAB accreditation/reaccreditation or PPHR recognition, such as approval notification or certificate; it is not necessary to upload the evidence submitted for accreditation/recognition.	Review annually and update as necessary.

Critical Contact Sheet (CCS)

Definition

The CCS form is used to maintain accurate, up-to-date information for essential personnel. Contact information for every position is required. However, it is acceptable for a single contact to routinely cover multiple positions. Enter the same contact information for each relevant position. Vacant positions must include contact information for the person providing temporary coverage for that function.

Element	Data Entry Guidance	Significance
Primary CDC PHEP project officer	Provide the name of the current primary CDC PHEP project officer and related contact information	
Backup CDC PHEP project officer or team lead	Provide the name of the current and backup CDC PHEP project officer or team lead assigned and related contact information	
U.S. marshal	Provide the name of the current U.S. marshal and related contact information	U.S. marshal often serves to verify receipt, stage, store (RSS) security
Backup U.S. marshal	Provide the name of the backup U.S. marshal and related contact information	
Health department emergency operations center (EOC)	Provide the general contact number and address for the health department or emergency management EOC. If there is not a health department EOC number this can be skipped, but the emergency management agency (EMA) EOC number and address must be entered.	
Health department EOC: 24/7 phone number	Provide the current emergency contact number for the health department	
Health department EOC: primary contact name	Provide the name for the current primary health department contact. If this is dependent on type of incident or event, provide the position title that will be responsible during a response. Contact information for the on-call duty officer, after-hours service, or dispatch is acceptable.	
Continuity of operations (COOP) EOC	Provide the name and address of the current COOP primary contact; if this is dependent on type of incident or event, provide the position title that will be responsible.	
EMA EOC	Provide the name and address of the current primary emergency management agency contact. If this is dependent on type of incident or event, provide the position title that will be responsible.	
Health commissioner, secretary of health, state health officer (SHO), minister of health	Provide the name of the lead health officer or health commissioner for the jurisdiction and related contact information.	

Element	Data Entry Guidance	Significance
PHEP director	Provide the name and related contact information of the PHEP director	
Medical countermeasure (MCM) coordinator & backup coordinator	Provide the name of the MCM coordinator/backup coordinator and related contact information	
CHEMPACK coordinator	Select "Yes" if the CHEMPACK coordinator is the same as the MCM coordinator. If CHEMPACK coordinator is someone different, provide related contact information.	
Law enforcement agencies responsible for MCM security	Provide the name of the current law enforcement agency primary contact and related contact information. If this is dependent on type of incident or event, provide the position title that will be responsible. The agency phone number or non-emergency dispatch number must be entered if a position title (rather than person) is listed as the security contact.	
Backup law enforcement agency responsible for MCM security	Provide the name and related contact information for the current backup law enforcement agency or department contact.	
Distribution (RSS) lead, supervisor, or chief: name	Provide the name of the current public health department personnel that serves as the distribution planning lead. A contractor is not an acceptable entry.	
Backup distribution lead: name	Provide the name of the current public health department personnel that serves as the distribution planning lead backup. A contractor is not an acceptable entry.	
Department of health, public information officer (PIO)	Provide the name of the PIO and related contact information	
Department of health, Deputy IO	Provide the name of the deputy PIO and related contact information.	
Influenza program coordinator	Provide the name and related contact information of the current public health department point of contact for the influenza program/coordinator.	
Immunization program coordinator	Provide the name and related contact information of the current public health department point of contact for the immunization program/coordinator.	
Laboratorian	Provide the name and related contact information of the current public health department laboratory point of contact.	
Epidemiologist	Provide the name and related contact information of the current public health department epidemiology point of contact.	

Reviewer Guidance	Required Documentation	Submission Frequency
Review information for accuracy and completeness regarding staff names, titles, and contact information. Confirm email and phone numbers work and are actively monitored and test the 24/7 number. If a position is vacant, contact information for the staff providing temporary coverage is required; coverage of multiple positions by the same person is acceptable. For instance the MCM coordinator might also cover CHEMPACK coordination.	• CCS variables must be complete.	CCS must be reviewed and updated as necessary every six months at a minimum. Update immediately if there is a change to any contact information or staff vacancy.

Jurisdictional Data Sheet (JDS)
States, Directly Funded Locality (DFLs), Local Planning, Jurisdictions, Territories and Freely Associated States (TFAS)

Definition

The JDS is used to gather information about the jurisdiction's population and staffing to support medical countermeasure distribution and dispensing. Plans must provide coverage for the entire jurisdictional population given a worst-case scenario. Local planning jurisdictions includes locals with Cities Readiness Initiative (CRI) funding.

Element	Data Entry Guidance	Significance
JDS.State1, JDS.DFL1, JDS.TFAS1, JDS.CRI1 *Jurisdiction population.*	Population will be automatically entered using Census Bureau data (www.census.gov). If adjustments to the population estimate are necessary to account for commuters, tourists, or other impacts, insert a modified population. Provide reasons and source(s) used to update the population in the comments.	MCM dispensing and administration includes vaccines, antiviral drugs, antibiotics, and antitoxins. Dispensing and administrating might require different footprints and staffing rhythms. Identify capacity for both operations in the JDS. Overall population coverage is based on a scenario that requires dispensing/administering MCM to the entire population within 48 hours.
JDS.State2 *Number of city, county, local, and tribal health departments.*	Provide the number of all health departments (not just CRI areas) within the state.	
JDS.State3 *Number of county, city, tribal, and local health departments required to develop local mass prophylaxis plans.*	Provide the number of all health departments (not just CRI areas) required to develop mass prophylaxis plans. This number should not be greater than the number of counties, cities, tribes, and local health departments referenced above.	
JDS State4, JDS.DFL2, JDS.TFAS2 *Total sites that receive materiel directly from the RSS facility.*	Given worst-case scenario for the primary risk-based threat, provide the total number of sites that receive materiel directly from the RSS whether regional distribution or local dispensing sites (Point of Dispensing (POD) or Dispensing/Vaccination Clinic (DVC)).	Awareness of total number of sites receiving MCM from RSS is necessary to effectively manage distribution and dispensing to the jurisdiction.
Closed POD (CPOD) section.	Collect information about types of CPODs, including health care entities, businesses, government agencies, military installations, academic institutions, and community-based agencies.	CPOD aggregate coverage is used to determine population covered by open POD or alternate sources. In a worst-case scenario, open PODs are used to prophylax those not covered in CPOD plans.

Element	Data Entry Guidance	Significance
JDS.State5a, JDS.DFL3a, JDS.TFAS3a, JDS.CRI2a *Jurisdiction dispenses* ***prophylaxis*** *directly to public health responders or critical infrastructure personnel (CIP).*	Select "yes" if the jurisdiction dispenses through a closed POD.	
JDS.State5b, JDS.DFL3b, JDS.TFAS3b, JDS.CRI2b *Jurisdiction administers* ***vaccine*** *directly to public health responders or CIP.*	Select "yes" if the jurisdiction administers through a closed DVC. Select "no" if not responsible for coverage.	
JDS.State6, JDS.DFL4, JDS.TFAS4, JDS.CRI3 *Population served by CPODs*	Provide the total number of people the type of CPOD is intended to serve. Estimate should include family and friends that will receive MCM from this location.	
JDS.State7, JDS.DFL5, JDS.TFAS5, JDS.CRI4 *Number of CPODs.*	Provide the aggregate number of CPODs in the jurisdiction. States must provide total number of CPODs in CRI and other local jurisdictions across entire state.	Jurisdiction awareness of written CPOD plans validates overall coverage.
JDS.DFL6, JDS.TFAS6, JDS.CRI5 *Number of CPODs exercised.*	Provide annual number of CPODS (if any) that were exercised at any level (drill, functional exercise (FE), full-scale exercise (FSE), or event or incident).	
JDS.DFL7, JDS.TFAS7, JDS.CRI6 *Number of agreements in place with dispensing sites using alternate dispensing methods.*	Provide a total number for any other MCM dispensing sites used to reach any individuals within the population who cannot access designated open or CPODs. For the purposes of this estimate, consider drive-through PODs as open PODs, not alternate methods of dispensing.	
Open POD section		
JDS.State8, JDS.DFL8, JDS.TFAS8, JDS.CRI7 *Total number of designated primary open (public) PODs.*	Provide the total number of public PODs in the jurisdiction that would open to give prophylaxis to the entire population. Do not include backup PODs in this number. For the purposes of this estimate, consider drive-through PODs as open PODs, not alternate methods of dispensing. States must include total number of public PODs in CRI and other local jurisdictions that would open to give prophylaxis to the entire population. Do not include backup PODs in this number.	

Element	Data Entry Guidance	Significance
JDS.DFL9 JDS.TFAS9, JDS.CRI8 *Population to be covered by open PODs.*	This is automatically calculated based on individuals not included in the total closed POD population estimate. The information should be used in conjunction with the POD planning form for the worst-case scenario with the jurisdiction dispensing to the entire population.	Population not covered by CPOD must be covered by open PODs. Remaining population equals number to cover within 48-hour window in worst-case scenario.
JDS.DFL10, JDS.TFAS10, JDS.CRI9 *Open PODs: total population per hour to process.*	This is automatically calculated based on the following formula: $\frac{\textit{Remaining population to be covered by open PODs}}{\textit{Hours available to complete dispensing operations}}$	Whether PODs have the same footprint and throughput or not, throughput per hour must meet worst-case scenario capacity. Estimated number per hour allows for planning based on throughput of all identified open PODs. However, consideration also must be given for any PODs using a head of household model, which allows one family member to receive prophylaxis for other family members, reducing the number of individuals who must visit open PODs to meet population needs in a worst-case scenario.
JDS.DFL11, JDS.TFAS11, JDS.CRI10 *Roll-up: Current number of open PODs.*	This must be your actual number of primary PODs. If you have based the number of PODs on the actual number of PODs needed to meet throughput, the number should match the calculation in the "Actual number of open PODs needed to meet throughput."	This number should line up with number of primary PODs listed in CAP8.5.
JDS.State9, DFL12, JDS.TFAS12, JDS.CRI11 *Number of open PODs exercised.*	Provide annual number of open PODs (if any) that were exercised at any level (drill, FSE, or incident).	

Reviewer Guidance	Required Documentation	Submission Frequency
Review information for accuracy and completeness. The JDS must provide a complete picture of the jurisdiction's capacity to provide MCM coverage to the entire population given a worst-case scenario requiring provision of MCMs to the entire population within 48 hours.	JDS variables must be complete.	At a minimum, review annually and update as necessary.

Partner Planning Sheet (PPS)

Definition

The PPS synthesizes information about how each reported partner supports public health preparedness and response. Strong, fully engaged community (jurisdictional) partners are critical for public health preparedness. Public and private partners are often perceived as trusted sources and support preparedness by working with the health department to provide input and mitigate identified health risks for the communities they serve. Partners also help identify community roles and responsibilities and coordinate the delivery of essential health services to strengthen community resilience as early as possible before, during, and after a public health emergency. Jurisdictions can leverage partner insights to develop and disseminate information that address the needs of at-risk populations that may be disproportionately impacted by the incident or event.

Element	Data Entry Guidance	Significance
PPS1.a-h *Partner Detail* *a. Partner name* *b. Access and functional needs group represented* *c. Preparedness phase of partner engagement (pre-incident, response, recovery)* *d. Participation in jurisdictional risk assessment (JRA)* *e. Communication support (public information and warning)* *f. Exchange of information between governmental agencies (information sharing)* *g. Participation in training* *h. Participation in exercises or incidents/events*	Submit partners that support public health preparedness, response, or recovery activities. Identified partners may support risk-mitigation, coordinate delivery of public health messages and services, and improve emergency operation and preparedness services for their communities. **Capability 1, Function 2:** Strengthen community partnerships to support public health preparedness. **Capability 1, Function 3:** Coordinate with partners and share information through community social networks. **Capability 1, Function 4:** Coordinate training and provide guidance to support community involvement. **Capability 2, Function 2:** Support recovery operations for public health and related systems for the community. **Capability 4, Function 3:** Establish and participate in information system operations. **Capability 4, Function 5:** Issue public information alerts, warnings, and notifications. **Capability 5, Function 2:** Identify and facilitate access to public health resources to support fatality management. **Capability 6, Function 1:** Identify stakeholders. **Capability 7, Function 1:** Determine public health role in mass care operations.	Engaging community partners that work with at-risk populations is essential for preparedness planning. The 2019 Pandemic and All-Hazards Preparedness and Advancing Innovation Act (PAHPAIA), Public Law No. 116-22 requires the health and medical needs of all individuals, including at-risk populations, be protected. The Americans with Disabilities Act (ADA) also protects people with disabilities and prohibits discrimination. Updated in 2008, the ADA Amendments Act (ADAAA) mandates that individuals with access and functional needs be included in all disaster plans developed for a community under Title II. PAHPAIA defines at-risk individuals as children, pregnant women, older adults, individuals with disabilities, or others who may have access or functional needs in the event of a public health emergency, as determined by the Secretary of Health and Human Services. See Integrating People with Access and Functional Needs into Disaster Preparedness Planning for States and Local Governments, HHS 2020.

Reviewer Guidance	Required Documentation	Submission Frequency
PPS1.a Evidence must document the partner name. Check data entry for accuracy. **PPS1.b** Not all partners are engaged with AFN populations. However, for partners that represent those populations, evidence must document which AFN populations are represented using the CMIST framework. CMIST is an acronym for Communication; Maintaining Health; Independence; Support, Safety, and Self-Determination; and Transportation. Examples of partners using CMIST include groups that work with older adults; children and youth; people with chronic illnesses and disabilities; people experiencing homelessness and transportation instability; and people with language barriers. Note: Partners identified for information sharing between government agencies (see PPS1.f) may not represent AFN stakeholders. May indicate N/A for these partners. See also PAR3.a for additional guidance. **PPS1.c** Not all partners are engaged during all stages of an incident, nor in all roles. Evidence must define the responsibilities of each partner and describe when the partner is involved based on the phases of preparedness (pre-incident planning, response, and recovery). If partners are identified that do not participate in all phases of response, probe the jurisdiction for clarity about any additional partners that may complement the missing phase of representation. Credit is still given for the engaged partner if evidence documents involvement in the selected phase(s). **PPS1.d** Public health JRAs must be conducted once every five years. A collaborative and flexible risk assessment includes input from HCCs and other health care organizations, as well as other community partners and stakeholders. Evidence must substantiate that indicated partners were involved and at minimum include partners from HCCs or other healthcare organizations . See also CAP1.1.	At minimum, partner documentation must indicate both parties (health department and partner) acknowledge roles and responsibilities of the engagement. There is no required format to present evidence of partner engagement, but evidence must demonstrate ongoing engagement with each identified partner. Acceptable Evidence • After-action report (AAR) or other exercise planning document with partner named in exercise participant list at minimum; identified role in exercise including any role in exercise planning is preferred. • Partner planning worksheet/matrix. • **PPS1.e** At least two examples (required) of participation by partners in the JRA or equivalent that represent populations likely to be disproportionality impacted by an incident/event. • Sign in logs demonstrating participation in various meetings. • Written agreements with agencies/ stakeholders; signatory pages; letters of acknowledgement; memoranda of understanding/agreement (MOUs/MOAs), etc.	At a minimum, review annually and update as necessary.

Reviewer Guidance	Required Documentation	Submission Frequency
PPS1.e Review level of coordination with partner to develop and disseminate information with respective populations. Effective message development and dissemination requires active participation by key partners. Partners may be used to leverage community networks to provide input or respond to information prior to, during, or after an incident. Crosswalk evidence with relevant ORR operational submissions. **PPS1 f** Review documentation for partner's ability to exchange health-related information and situational awareness among federal, state, local, territorial, and tribal levels of government and the private sector. This must include routine sharing of information, as well as issuing of public health alerts across any levels of government in preparation for, and in response to, events or incidents of public health significance. Credit for *joint functional exercise with emergency management and HCC* must demonstrate some level of information exchange. See Section 3: Operations, PAR3. **PPS1.g-h** Community preparedness stipulates training and participation in exercises, incidents, and events help solidify roles, increase knowledge, and support community involvement in preparedness efforts. Evidence must substantiate that partners involved in response and recovery are actively engaged in training and exercises. Crosswalk evidence with ORR operational submissions.		

Workforce Development and Training (WDT)

Definition

According to principles outlined by the Homeland Security Exercise and Evaluation Program (HSEEP), the foundation of preparedness is built on plans, trainings, and exercises. Jurisdictional priorities must guide the development of exercise objectives and related staff training and practice. Simulations and real-world experiences can substantiate preparedness efforts when incorporated in a progressive, coordinated manner through planned staff training and education.

Element	Data Entry Guidance	Significance
WDT1.a-b *Workforce development for preparedness includes* *a. Training requirements and* *b. Documentation and tracking.*	Based on jurisdictional capacity, a preparedness-specific workforce development training plan must be in place, at minimum, for preparedness staff and ideally agencywide. Provide information about how required elements of preparedness and response training are tracked for all applicable public health staff. Documenting the completion of required training is an important step in assuring workforce capacity.	Workforce development can be challenging to strategically plan. A comprehensive approach to training builds a capable and competent workforce. Maintaining professional development for preparedness can maximize training investments and lead to better response, outcomes, and recovery.

Reviewer Guidance	Required Documentation	Submission Frequency
WDT1.a-b Review workforce development and training plans for all phases of the preparedness cycle, relative to the needs of the jurisdiction. The National Incident Management System (NIMS) and Incident Command System (ICS) or equivalent trainings must be documented for the preparedness and response workforce, at minimum. Examine the plan for completeness and probe for missing information that must be included.	Acceptable Evidence • Examples of a general plan or process to develop and train applicable preparedness staff or the entire health department; plan can be specifically focused on preparedness training or it can be an agency-wide training plan that includes preparedness topics. • Individual staff development plans. • PHAB accredited jurisdictions can submit documentation submitted for Measure 8.2.3A, professional and career development for all staff. • PPHR recognized jurisdictions can submit documents submitted for PPHR measure #3, completion and maintenance of workforce development plan and staff competencies, sections A (training topics), C (training delivery), and D (workforce development, maintenance, and tracking). • Workforce development training plan or equivalent.	At a minimum, review and submit annual updates

Element	Data Entry Guidance	Significance
WDT2 *Integrated preparedness planning workshop (IPPW) date*, formerly training and exercise planning workshop (TEPW).	**WDT2** Provide date of most recent workshop.	The IPPW is a meeting that establishes the strategy and structure for an exercise program, in addition to broader preparedness efforts, while setting the foundation for the planning, conduct, and evaluation of individual exercises. This meeting should occur on a periodic basis depending on the needs of the program and any grant or cooperative agreement requirements (HSEEP 2020).

Reviewer Guidance	Required Documentation	Submission Frequency
WDT2 Evidence must include the most recent date; annual plans must have an electronic date stamp or equivalent within one year of the budget period for which the training plan is reviewed. Crosswalk evidence with ORR operational submissions. Confirm naming convention and dates for overlapping drills, exercises, and incidents align.	Acceptable Evidence • Examples of process in place to develop and train all applicable preparedness staff, either focused training or as part of agency-wide training. • TEPW or IPPW.	At a minimum, review and submit annual updates.

Element	Data Entry Guidance	Significance
WDT3.a-b *Multiyear integrated preparedness planning (IPP), formerly MYTEP, includes* *a. Number of additional planning years and* *b. Area(s) for improvement.*	**WDT3.a** A progressive exercise approach requires a multiyear cycle, adjusted annually to reflect unexpected changes in focus or priority. Provide a progressive multiyear exercise program that describes a series of increasingly complex exercises, which builds on the previous plan. Multiyear IPP must reflect, at minimum, three additional years of planning beyond the current budget period, resulting in a four-year training plan. **WDT3.b** From operational requirements submitted (see OPS1.i) select those tabletop, functional, or full-scale exercises or incidents that were referenced during the IPPW to inform and update current and future yearly training and IPP. Include incidents that altered exercise priorities and objectives in the current and subsequent year plans. Use the same naming convention for the same exercises and incidents when entering throughout the ORR (see OPS1.b). Include all areas identified during the past year that were on the current IPPW. Include capability, applicable function, task, and any relevant improvement documentation. Corrective actions and improvement areas should be tracked and continually reported on an annual basis until issues are resolved and improvements made.	The IPP combines elements of the integrated preparedness cycle to encourage scheduling and conducting risk assessments, plans, and training prior to exercises in each cycle for a more integrated, validation function. Preparedness priorities help exercise planners design and develop a multiyear exercise program that should have a linear approach to quality improvement (HSEEP 2020).

Reviewer Guidance	Required Documentation	Submission Frequency
Consistent with the HSEEP 2020 approach to exercise planning, PHEP recipients are expected to create a progressive, multiyear training and exercise program with increasingly complex exercises to improve operational readiness across multiple hazards. **WDT3.a** Multiyear IPPs must include at least three additional years of planning beyond the current budget period (four years total) of progressive exercise planning with a focus on preparedness priorities. **WDT3.b** Evidence for improvement areas are linked to operational submissions. The indicated topic area or description must be consistent with the conclusions reached from the exercise or incident/event. Evidence must also demonstrate a continuous process of tracking and addressing areas of improvement as part of the preparedness training cycle.	Acceptable Evidence • AARs. • Real world incident corrective actions. • TEPW/IPPW meeting notes or other evidence of integrated preparedness priorities. • Training plans with exercise participation included.	At a minimum, review and submit annual updates.

Section 2: Evaluation of Plans

Section Organization

The ORR is organized into three sections: 1) descriptive and demographic, 2) planning, and 3) operations. Section 2 provides guidance about reporting and evaluating jurisdictional plans, by capability, and is organized as described below.

The dark blue tables provide information about the specific element, pertinent detail on what is required for data entry, and why it is important. The light blue tables describe how the reviewer will evaluate the information and when updates are required (submission frequency). Whether responsible for data entry or review, jurisdictions should read both tables to fully understand the ORR guidelines.

Element	Purpose	Significance
Standardized nomenclature is used to label each measure. Elements and sub-elements are uniquely labeled based on which capability is referenced from the Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health. For example, "CAP1.1a" refers to Capability 1: Community Preparedness, element 1, sub-element a.	The purpose of the measure is explained and reference made to each capability's applicable function, task, and resource from the Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health. The ORR does not measure every function, task, or resource element for each capability.	The implication of the measure is described.

Reviewer Guidance	Required Documentation	Submission Frequency
Reviewer guidance provides detail and clarifies expectations about content components the reviewer must identify to deem the information acceptable as sufficient evidence.	Required documentation provides examples about the type of information recipients can submit as evidence to substantiate responses to elements. The examples of required documentation are not exhaustive. Evidence must include a creation or revision date that is in the acceptable range for a given element's submission frequency (annual, three years, or five years). Draft documents, such as updates to plans or AARs, are acceptable with written acknowledgement by the PHEP director, or proxy, that the evidence is valid and used to support the PHEP program. Draft plans that do not meet the criteria will be adjudicated by the reviewer as **insufficient evidence** in the ORR.	Submission frequency details when ORR data must be submitted for documentation and validation. **Review** means the data entered should be reexamined for accuracy. **Update** means any data that is no longer accurate should be edited. **Validate** means that supporting evidence must be routinely maintained and documents must have dates within the required range.

Capability 1: Community Preparedness

Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health

Definition

Community preparedness is the ability of communities to prepare for, withstand, and recover from public health incidents in both the short and long term. Public health supports community preparedness through engagement and coordination with a cross-section of state, local, tribal, and territorial partners and stakeholders to

- Support the development of public health, health care, human services, mental/behavioral health, and environmental health systems that support community preparedness
- Participate in awareness training on how to prevent, respond to, and recover from incidents that adversely affect public health
- Identify at-risk individuals with access and functional needs who may be disproportionately impacted by an incident or event
- Promote awareness of and access to public health, health care, human services, mental/behavioral health, and environmental health resources that help protect the community's health and address the access and functional needs of at-risk individuals
- Engage in preparedness activities that address the access and functional needs of the whole community as well as cultural, socioeconomic, and demographic factors
- Convene or participate with community partners to identify and implement additional ways to strengthen community resilience
- Plan to address the health needs of populations that have been displaced because of incidents that have occurred in their own or distant communities, such as after a radiological or nuclear incident or natural disaster

Element	Purpose	Significance
CAP1.1a *Date of the most recently conducted JRA or equivalent.*	JRA identifies potential hazards, unique vulnerabilities, and community risk factors that could impact the jurisdiction's public health, medical, and mental/behavioral health infrastructure. **Capability 1, Function 1:** Determine risks to the health of the jurisdiction. **Task 1:** Conduct a public health JRA. Identify and prioritize jurisdictional risks, risk-reduction strategies, and risk-mitigation efforts in coordination with community partners and stakeholders. **P1: (Priority)** Procedures in place to identify at-risk populations that may be disproportionately impacted by incidents or events.	A JRA collates a multitude of inputs and yields an output that identifies contributing factors that might impact health outcomes in the jurisdiction. A collaborative and flexible risk assessment should include input from existing hazard and vulnerability analyses including those from emergency managers and community partners (health centers, faith-based groups, etc.). The identified threats and hazards are used by preparedness programs to strengthen planning and response protocols and capabilities.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP1.1a Evidence must document the jurisdiction's **most recent JRA (or equivalent) was conducted within five years at the time of review.** The evidence must demonstrate that relevant population estimates obtained from the U.S. Census Bureau or other relevant sources were used to estimate the jurisdictions' population size and demographic characteristics. Crosswalk evidence with PPS for inclusion of partners representing populations with access and functional needs.	Acceptable Evidence • Any risk assessment that includes a health component is acceptable. • Documentation that the assessment was conducted within the last five years. Documentation must include month and year. • Signature or acknowledgment by designated health official such as PHEP directors, emergency managers, or other authority responsible for conducting the risk assessment.	At a minimum, review annually and update as necessary; JRA or equivalent must be conducted, at a minimum, every five years.

Element	Purpose	Significance
CAP1.1b *Hazards identified in the assessment.*	JRA identifies potential hazards, unique vulnerabilities, and community risk factors that could impact the jurisdiction's public health, medical, and mental/behavioral health infrastructure. **Capability 1, Function 1:** Determine risks to the health of the jurisdiction. **Task 1:** Conduct a public health JRA. Identify and prioritize jurisdictional risks, risk-reduction strategies, and risk-mitigation efforts in coordination with community partners and stakeholders. **P1: (Priority)** Procedures in place to identify at-risk populations that may be disproportionately impacted by incidents or events.	A **hazard analysis** or risk assessment evaluates potential hazards, vulnerabilities, and resources in a specific jurisdiction. The analysis assists preparedness planning by identifying potential targets that will likely impact a given community.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP1.1b Review the list of threats and hazards identified given the geographic and population composition of the jurisdiction. Jurisdictions should be encouraged to select all hazards identified in the JRA (or equivalent) but must document at least five jurisdictional hazards including pandemic influenza. Jurisdictions with a primary planning scenario based on anthrax must also include anthrax among the minimum of five hazards.	Documentation that identified hazards were included in the JRA or equivalent.	At a minimum, review annually and update as necessary; JRA or equivalent must be conducted a minimum of every five years.

Element	Purpose	Significance
CAP1.2 *Process in place for transporting people during an emergency (select lead, support, or no role).*	Addressing respective roles and responsibilities of public health agencies, transportation partners, and other relevant entities is important to safeguard population movement and plan for potential transportation challenges during an emergency. **Function 1:** Determine risks to the health of the jurisdiction; **P1: (Priority)** Procedures in place to identify at-risk populations that may be disproportionately impacted by incidents or events. The CMIST framework or similar whole community planning framework is used to help planners build on five basic access and functional needs categories that should be addressed in an emergency: • Communication • Maintain Health • Independence • Safety, support, self-determination, and • Transportation Within the CMIST framework, transportation refers to Individuals who may lack access to personal transportation, who are unable to drive due to decreased or impaired mobility that may come with age and/or disability, temporary conditions, injury, or legal restriction. See ORR PPS for more detail about the CMIST framework and PHEP significance.	Disasters can significantly reduce transportation options for all individuals. Limited access to reliable transportation can potentially influence compliance with public health recommendations, especially evacuation orders. The U.S. Government Accountability Office also notes the people with limited transportation options include • Low-income, homeless, or transient persons who do not have a permanent residence • People who, for any other reason, do not own or have access to a personal vehicle • Older adults and persons with disabilities who have mobility impairments that prevent them from driving • People who need medical equipment in order to travel • Children without a legal driver present to transport • Tourists and commuters who are frequent users of public transportation • People with limited English proficiency who rely on public transit.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP1.2 Evidence must document the lead agency, public health or other, and substantiate the roles and responsibilities for transportation during an emergency as bulleted below. The intent of this element is to document the process for meeting the transportation needs of the whole community. Disasters can significantly reduce transportation options, inhibiting individual's timely evacuation to shelters and essential services. The safe evacuation of individuals during an emergency requires pre-disaster coordination with mass transit and accessible transportation services providers and community organizations (schools, assisted living centers, disability organizations, transitional housing, senior/aging services, migrant farmworker councils, etc.) in order identify transportation needs, assets, and options. The transportation plan must address the following: • Alignment of transportation plans with transportation-dependent population data in JRAs. • Plan for identifying nontraditional emergency transportation providers. • Process for bidirectional flow of information to and from (and vice versa) community partners serving populations with access and functional needs including tourists or non-residents who may have limited access to radio, television, or Internet. • Plan for coordination with paratransit services to ensure individuals who rely on these services daily will have access during an evacuation when there is high demand. • List of transportation resources, vehicle capacity and whether the vehicle can accommodate wheelchairs/medical equipment, service animals.	Jurisdictions must provide evidence of plans for supporting transport of people during an emergency. If public health is not the lead, transportation plans from the lead agency are acceptable. Regardless of role, preparedness programs are responsible for understanding how the needs of people with access and functional needs are covered in jurisdictions. Plans must include an estimate of transportation assets available to support evacuations and other movement needs during an emergency. Transportation plans must also address coverage for surges in population from commuters and tourists. As applicable, plans must also address transportation disadvantaged populations that might routinely rely on mass transit (public buses, school buses, subways, etc.), paratransit and senior transportation services, transportation voucher programs, or Veterans Affairs transportation programs. Acceptable Evidence • Document transportation assets using Support Vehicle/Equipment Inventory (ICS 218). • Health Preparedness Program (HPP) resource gap analysis (health care preparedness capability 4, Objective 2, Activity 1) or equivalent with estimates of transportation resources for evacuation. • Memorandums of understanding (MOU) or equivalent documenting transportation agreements with alternative providers, if applicable.	At a minimum, review annually and update as necessary; validate at least every three years any plans with transportation components.

Element	Purpose	Significance
CAP1.3 *Evidence of process to integrate trusted spokesperson or agent representing individuals with access and functional needs to deliver public health messages.*	The whole community needs access to accurate and timely information to stay safe before, during, and after a public health threat or disaster. **Function 2:** Strengthen community partnerships to support public health preparedness. **Task 4:** Engage trusted community spokesperson to deliver public health messages. **Function 3:** Coordinate with partners and share information through community social networks. **Task 1:** Engage with community partners and stakeholders to coordinate preparedness efforts. **Task 3:** Leverage community networks to disseminate information during an incident.	In 2011, the United States adopted a whole community approach to emergency management policies and practices. This approach suggests emergency planners identify and integrate community partners to help develop effective communication strategies for individuals with access and functional needs. For information to be actionable, it must be communicated in a format and language that the population can access and understand, and to be effective, messages must be culturally appropriate and from a trusted source. Media outlets that serve minority groups play a key role in disseminating culturally appropriate messages. Individuals with access and functional needs and partner organizations also have valuable insights on whether pre-developed preparedness and disaster communication messages and materials are accessible, understandable, and culturally and linguistically appropriate for the populations they are intended to inform.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP1.3 Evidence must document the process of disseminating necessary information during an emergency through trusted spokespersons and messengers of community stakeholders. Trusted spokespersons can be health department staff and leaders of community or faith-based organizations, and advocacy groups. Crosswalk partner evidence with the PPS.	Acceptable Evidence • Evidence of partner/stakeholders trusted spokesperson (MOU, partner contact lists, meeting attendance, participation by spokesperson in development/review of risk messages and materials, or participation in exercises or responses. • Plans describe process for identifying and integrating community access and functional needs partners in the development, review and/or dissemination of important public health risk information. • Worksheet or equivalent of roles for all identified partners in the dissemination of crisis and emergency risk communications (CERC).	At a minimum, review annually and update as necessary; validate at least every three years

Capability 2: Community Recovery

Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health

Definition

Community recovery is the ability of communities to identify critical assets, facilities, and other services within public health, emergency management, health care, human services, mental/behavioral health, and environmental health sectors that can guide and prioritize recovery operations. Communities should consider collaborating with jurisdictional partners and stakeholders to plan, advocate, facilitate, monitor, and implement the restoration of public health, health care, human services, mental/behavioral health, and environmental health sectors to a level of functioning comparable to pre-incident levels or improved levels where possible.

Element	Purpose	Significance
CAP2.1a-f *Community recovery (post-incident) plans address* *a. Assessment of public health recovery needs,* *b. Assessment of recovery services provided by the public health system,* *c. Mental/behavioral health,* *d. Environmental health,* *e. Human/social services, and* *f. Review of integrated recovery coordination plans with key community partners.*	Community recovery is the ability of communities to identify critical assets, facilities, and other services within public health, emergency management, health care, human services, mental/behavioral health, and environmental health sectors that can guide and prioritize recovery operations. **Capability 2, Function 1:** Identify and monitor community recovery needs. **P1: (Priority)** Procedures in place for collaborating with jurisdictional partners and stakeholders to determine community recovery priorities and to define jurisdictional public health agency role(s) in community recovery. **P2: (Priority)** Procedures in place for how the jurisdictional public health agency and jurisdictional partners and stakeholders will assess, conduct, monitor, document, and follow up with public health, emergency management, health care, etc. **Task 1:** Identify jurisdictional community recovery priorities **Task 2:** Identify the jurisdictional public health agency role in community recovery. **Task 3:** Identify recovery services to be provided by the jurisdictional public health agency, partners, and stakeholders.	Disasters can have a huge impact on the physical and mental well-being of people in the affected communities. State and local public health agencies play an important role in recovery activities. Monitoring the public health, medical and mental/behavioral health infrastructure is an essential public health service. This element aligns with many aspects of Capability 1, including partner engagement.

Reviewer Guidance	Required Documentation	Submission Frequency
Evidence must substantiate that public health, whether the lead agency or not, understands the roles and responsibilities for each sub-element. **CAP 2.1a** Evidence for assessment of recovery needs must describe a process for determining recovery priorities within the jurisdiction. Evidence of process to collaborate or otherwise assess priorities must be provided. **CAP 2.1b** Evidence must document how recovery services provided by public health are assessed. Coordination of community recovery roles and process for exchanging information to identify recovery assets by involved sectors must also be described. **CAP 2.1c-e** Evidence must specifically document what agency is the lead for health care, mental/behavioral health, and environmental health issues. Evidence must also describe public health's role (whether lead or support) in delivering mental/behavioral health services, environmental health and human/social services during and following an incident. **CAP 2.1f** Evidence must document a continuous quality improvement (CQI) process that includes partner engagement and participation in planning, reviewing, and exercising roles during responses and recovery. CQI is a key component of evaluation, and evidence must demonstrate the jurisdiction maintains a review cycle to address any necessary updates following the identification of improvement areas, which are generally identified after a response or exercise. For example, updates might occur to SOPs, training schedules, exercise objectives.	Acceptable Evidence • Evidence that partners are engaged in planning and exercising as part of CQI, including engagement in training and exercise planning and review of specific responsibilities. • Plans, annexes, manuals, standard operating procedures/guidelines (SOP/SOG), policy/statutes, contact list of jurisdictional services used during recovery. At minimum, partners engaged in community recovery must be listed on the PPS within the ORR. Health departments must also provide supplemental evidence that documents the history of engagement for each identified recovery partner with specificity about the partner's role.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP2.2 *Process for notifying/informing the community of available public health services.*	Assess the health department's plan or process to communicate services available during recovery. **Function 2:** Support recovery operations for public health and related systems for the community. **P1:** Integrated recovery coordination plan that accounts for the jurisdictional public health agency lead or support roles. **Task 1:** Coordinate with jurisdictional partners and stakeholders to develop recovery solutions. **Task 2:** Educate the community about public health services. **Task 4:** Notify the community of available public health services.	Timely, accurate, and actionable communications provide the whole community with critical and updated information throughout the recovery process.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP2.2 State health departments must document the process for coordination of recovery services with applicable agency and community partners. Evidence must also document states have awareness about the local process for coordination and outreach.	Acceptable Evidence • Evidence of a process for developing and providing relevant information about operable public health services, temporary provisions, and recovery activities following an incident/event. • Notes, rosters. or other documentation of evidence of partner engagement in planning process and partner role/s. • Plans, annexes, manuals, standard operating procedures/guidelines, policy/statutes, or contact list of jurisdictional services used during recovery.	At a minimum, review annually and update as necessary; validate at least every three years.

Capability 3: Emergency Operations Coordination

Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health

Definition

Emergency operations coordination is the ability to coordinate with emergency management and to direct and support an event or incident with public health, or health care, implications by establishing a standardized, scalable system of oversight, organization, and supervision consistent with jurisdictional standards and practices and the National Incident Management System (NIMS).

Element	Purpose	Significance
CAP3.1a *Date of most recent preparedness plans (or annexes) review or update.* **CAP3.1b** *Subject matter experts involved in developing plans.*	Identify the health departments ability to conduct a preliminary assessment to determine the need for activation of public health emergency operations. **Capability 3, Function 1:** Conduct preliminary assessment to determine the need for activation of public health emergency operations. **Task 1:** Determine public health response role. **Task 3:** Develop public health incident management structure **P1: (Priority)** Response procedures in place to detail how the agency manages and responds to situational awareness information that indicates when a jurisdictional incident with public health consequences requires an agency-level response. **P3:** Procedures in place for public health preparedness and response based on JRA findings that are coordinated with the jurisdictional emergency management agency. **P4:** Scenario-specific and all-hazards, response-based procedures in place that describe incident response strategies based on the nature and scope of the incident including pandemic influenza, anthrax, other emerging infectious disease, natural disasters, and intentional incidents.	Public health plays an integral role in preparing communities to respond to and recover from threats and emergencies. All state, local, tribal, and territorial emergency response stakeholders must be prepared to coordinate, cooperate, and collaborate with cross-sector partners and organizations when emergencies occur, regardless of the type, scale, or severity. Maintaining updated preparedness plans that align with jurisdictional hazards is essential to facilitate preparedness for, response to, and recovery from public health emergencies.

Reviewer Guidance	Required Documentation	Submission frequency
CAP3.1a-b Evidence must document input from supporting agency and program subject matter experts (SMEs), as appropriate, who were consulted about the emergency operations plan (EOP) including surveillance/ epidemiology, laboratory, health care, immunization, chemical, biological, and as applicable, radiological expertise.	Acceptable Evidence • **CAP3.1a** All-hazards plans; annexes that include detail about EOC operations. • **CAP3.1b** As applicable, document process for consultation with SMEs and pre-incident coordination with jurisdictional emergency management to help establish scope of public health involvement when activation of an EOC occurs. Document the process for including or consulting with appropriate SMEs for specific incidents identified in JRA (CAP1.1b) and describe how input is integrated in applicable emergency operation plans, functional annex, threat-specific annex, or similar incident-specific annex.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP3.2a-e *EOC or public health functions within another EOC, including* *a. Pre-event indicators,* *b. Notifications,* *c. Levels of activation,* *d. Staffing, and* *e. Demobilization.*	Identify public health risks of an incident or event and determine scale of incident management operations and necessary activations levels for public health response. **Function 1:** Conduct preliminary assessment to determine the need for activation of public health emergency operations. **Task 2:** Determine response activation levels based on complexity of the incident or event. **Function 2:** Activate public health emergency operations. **Task 1:** Activate public health incident command and emergency management functions. **Task 3:** Designate personnel coverage for multiple operational periods. **Task 4:** Establish primary and alternate locations. **P1: (Priority)** Procedures in place to manage, operate, and staff the public health EOC or public health functions within another EOC. **Function 4:** Manage and sustain the public health response **P1:** Standard operating procedures in place to manage a response. **Function 5:** Demobilize and evaluate public health emergency operations. **Task 1:** Return public health resources and staffing to their prior "ready state" of operations. **P1: (Priority)** Procedures in place for demobilization of public health operations.	For an effective response, it is critical that the health department defines: Criteria for EOC activation and demobilization, Specifics for operations during all phases of the response, and Staffing criteria, whether in the lead or supporting a response to facilitate an optimal organizational structure.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP3.2a Evidence about pre-event indicators must document any statutes or authority that governs public health activations to support a public health emergency (regardless of whether leading or playing a support role). If there is no defined authority, then at minimum the evidence must document the process for public health activations.	Acceptable Evidence • **CAP3.2a** Document key statutes that define the authority, roles, and primary responsibilities for the specific health jurisdiction. Provide documentation that describes pre-event indicators; SOPs or plans that include decision matrix, algorithms, and timelines.	At a minimum, review annually and update as necessary; validate at least every three years

Reviewer Guidance	Required Documentation	Submission Frequency
CAP3.2b Evidence must document the use of indicators, alerts, critical information requirements, and responses to notify staff about an EOC activation.	**CAP3.2b** Provide evidence of notification procedures, and staff roles authorized to activate the EOC.	
CAP3.2c Evidence related to public health's emergency operations must document, at minimum, a flexible, scalable incident management structure that is coordinated with jurisdictional or area command structures. Minimum staffing requirements for the EOC must also be documented. Activation plans must include the decision-making process and any relevant statutes and/or authorities that define circumstances, triggers, and levels of activation. Levels of activation must be based on triggers (defined by actual or anticipated levels of damage) and communication with the incident commander or unified command and must be linked to jurisdiction's risk analysis. ***Full activation*** includes all incident-related public health roles identified in the EOC organization chart. ***Partial activation*** includes core public health and supporting agencies personnel deemed necessary to support the response. EOC must be capable of independent and 24/7 operations for at least two weeks (FEMA's EOC Management and Operations Resource Guide, sustainability definition).	**CAP3.2c** Document circumstances that would lead to an EOC activation including a) who has authority and responsibility to make the decision to activate, b) what the circumstances are for activation, c) when the activation occurs, and d) how the level of activation is determined. Provide documentation that describes any thresholds for activation levels along with criteria for determining when a partial or full activation is necessary.	

Reviewer Guidance	Required Documentation	Submission Frequency
CAP3.2d Evidence must include plans for primarily staffing an EOC, backup staff support, and training. Staffing plans must also include evidence for a process for pre-identified staffing roles including primary and alternate(s); cross-training of staff that supports appropriate flexibility between ICS roles; partnerships identified for backfill by trained staff through mutual aid request; and resources for just-in-time training and/or shadowing until backfill is adequately prepared.	**CAP3.2d** Provide evidence for staffing plans including for long-term staffing rhythm. **States/DFLs/TFAS** General and incident command role plans must support a continuous staffing for at least a 14-day period. **Locals** Document how an emergency response that lasts longer than 24 hours will be managed including staffing needs, shift changes, and resource needs. As applicable describe process for assigning a local public health agency liaison to support the state or other emergency operation centers that might operate to support a local response.	
CAP3.2e Demobilization and deactivation usually occur in phases. Evidence must indicate when the health department resumes normal operations and how phasedown of response operations occurs.	**CAP3.2e** Document demobilization plans or equivalent for scaling down operations and transitioning workforce and resources to prior "ready state" operations.	

Element	Purpose	Significance
CAP3.3a-l *Plans include identified general and command staff roles* *a. Incident commander /unified command,* *b. Finance/administration section chief,* *c. Logistics section chief,* *d. Operations section chief,* *e. Planning section chief,* *f. PIO,* *g. Chief medical officer,* *h. Chief science officer,* *i. Epidemiologist,* *j. Infectious disease/influenza SME,* *k. Liaison officer, and* *l. Safety officer.*	The health department's ability to determine public health response roles, develop an incident management structure, and train responsible parties on those procedures are required. **Function 1:** Conduct preliminary assessment to determine the need for activation of public health emergency operations **Task 3:** Develop public health incident management structure **P2: (Priority)** Maintain a roster of primary and backup individuals who will serve as incident commander or manager and other key roles within jurisdictional incident management. **Function 2:** Activate public health emergency operations. **P3: (Priority)** Job action sheets or equivalent documentation for incident command positions and other public health incident management roles during a public health emergency.	A predetermined physical or virtual location and incident command staff are necessary to coordinate unified health command activities and facilitate an effective response.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP3.3a-l Evidence must document staffing plans for the general and command positions for incident commander, finance/administration section chief, logistics section chief, operations section chief, planning section chief, and PIO. **It is acceptable for one individual to cover multiple ICS roles; although primary and deputy positions covering the same position cannot be filled by the same person but rather must be distinct people.** Chief medical officer, chief science officer, epidemiologist, infectious disease/influenza SMEs are functional roles that support command staff as needed in the event of a pandemic influenza response. **At least one of these four must be included in the ICS plan for activation.** While these roles are not NIMS specific, jurisdictions must document how experts will be used during a response. Alternatively, evidence about the PIO and safety officer may be documented in related planning sections (emergency public information and warning (EPIW); see CAP4.1a, and responder safety and health; see CAP14.1a) but there must be specific evidence related to the role and responsibilities consistent with the ICS structure.	Acceptable Evidence • Current roster of primary and backup staff identified to serve as incident commander and other key roles. • SOPs, written agreements, EOC activation plans, job action sheets or equivalent documentation for incident command positions and other public health incident management roles.	At a minimum, review annually and update, as necessary; validate at least every three years

Element	Purpose	Significance
CAP3.4 *Process or procedures to request additional personnel and material resources from outside the health department and/or jurisdiction*	Local and state agreements support public health response related activities consistent with NIMS if the scope of the incident is larger than jurisdictional assets can support. **Function 2:** Activate public health emergency operations **P2: (Priority)** Mutual aid agreements or other agreements, such as local agreements, Emergency Management Assistance Compact (EMAC), and HCCs, as applicable, between public health agencies and response partners to support public health response-related activities. **Function 4:** Maintain and sustain the public health response **Task 2:** Track public health resources	Legal authority or an MOU with outside entities that expands normal operations to share resources, facilities, services, and other potential support required during a public health response is critical when the scope of the incident is greater than jurisdictional assets can adequately manage.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP3.4 Evidence must document what, if any, agreements are in place for shared staffing and emergency resources if required. If personnel agreements are in place, evidence must also indicate whether additional personnel assets are covered by volunteer management plans.	Acceptable Evidence • Examples of potential partner agreements or written processes to request support from: EMAC, Red Cross, Medical Reserve Corps (MRC), and emergency response teams (ERTs). • Mutual aid agreements or equivalent for shared resources; volunteer management plans.	At minimum, review annually and update as necessary; validate at least every five years

Element	Purpose	Significance
CAP3.5a-d *Plans document processes required to support a response* *a. Administrative preparedness plan,* *b. Allocating and tracking funding and resources,* *c. Incident action plans (IAPs), and* *d. Situation reports.*	To assess the health departments ability to develop and maintain incident response strategies and to maintain and sustain the public health response. **Function 3:** Develop and maintain an incident response strategy. **Task 1:** Develop incident action plans. **Task 2:** Update and share incident action plans. **P1: (Priority)** Capacity for producing incident action plans. **Function 4:** Maintain and sustain the public health response. **Task 2:** Track public health resources.	Achievement of this measure will verify the health department's ability to execute processes and protocols to communicate incident goals, operational period objectives and critical situation updates necessary to effectively manage and sustain a public health response. In addition, this will ensure that fiscal and administrative authorities and practices that govern funding, procurement, contracting, hiring, and legal capabilities necessary to mitigate, respond to, and recover from public health emergencies can be accelerated, modified, streamlined, and accountably managed at all levels of government.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP3.5a Evidence must describe resource management such as contracting, procurement, and emergency funding plans. For example, plans describe how emergency supplemental funds are timely processed. **CAP 3.5b** Administrative tracking evidence must describe the process for allocating and tracking of emergency funds and resources if they are necessary. **CAP 3.5c** Consistent with NIMS, evidence must document each operational period, associated response activities, and what triggers transition between operational phases. **CAP 3.5d** Consistent with NIMs, situation reports must document incident status, pertinent activities, and provide explicit details for the period covered.	Acceptable Evidence • Administrative preparedness plan or similar documents, SOPs, or job aids. • Applicable forms, templates, completed forms, tracking software, or SOPsSOGs or equivalent. • Specific templates or examples of incident action plans, situation reports, administrative tracking, and resource management documentation.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP3.6a-d *COOP plans identify* *a. Essential public health services,* *b. Orders of succession,* *c. Devolution, and* *d. Alternate location(s).*	To assess the ability to identify response priorities to ensure continuation and recovery of critical public health functions. **Function 4:** Manage and sustain the public health response. **Task 5:** Develop COOP plan(s) **P4: (Priority)** Procedures in place to ensure the continued performance of pre-identified essential functions during a public health incident.	Achievement of this measure will verify the health department's ability to execute functions that must be continued despite a natural disaster or emergency. During an incident it is critical to maintain pre-identified essential public health services in the absence of primary operational readiness.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP3.6a Evidence describes contingencies for maintaining essential public health services and must include provisions for personnel, maintaining vital records and databases operations, and obtaining necessary supplies and equipment. **CAP3.6b** Evidence for orders of succession must describe how continued operations under a succession plan occur. Delegation of authority if leadership is unavailable, debilitated, or incapable of performing legally authorized roles and responsibilities must be clearly described. Method of notification and limitations on delegations of authority by successors must also be designated. **CAP3.6c** Devolution of uninterruptible services must describe the transfer authority and responsibility for essential functions from the agency's primary operating staff and facilities to other agencies, employees, and/or facilities. COOP plans must address potential for scaled down operations. **CAP3.6d** Evidence of a location (or process to identify a location) that can be used to carry out essential functions is acceptable. Evidence that supports a virtual presence, if necessary, is acceptable.	COOP plans must document positions and staffing for maintenance of essential public health functions. Documentation must include functions that enable an organization to provide vital services; safeguard vital records such as legal documents and financial records; maintain the health of the general public; and continue essential functions that cannot suffer an interruption for more than 12 hours. <u>Acceptable evidence</u> • SOP, COOP plans, or annexes.	At a minimum, review annually and update as necessary; validate at least every three years.

Capability 4: Emergency Public Information and Warning

Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health

Definition

Emergency public information and warning is the ability to develop, coordinate, and disseminate information, alerts, warnings, and notifications to the public and incident management personnel. Emergency public information and warning capability is necessary during all phases of an incident to provide information on public health issues and public health functions through multiple methods to a variety of audiences.

Element	Purpose	Significance
CAP4.1a-b *Plans describe roles and responsibilities for* *a. PIO, and* *b. Deputy PIO.*	A PIO plays a critical role for information management and communication strategies. **Capability 4, Function 1:** Activate the emergency public information system. **Task 1:** Identify key public information personnel **P1:** Procedures in place to document roles and responsibilities for PIOs, spokespersons, and support personnel based on the incident and subject matter expertise.	PIOs are key members of incident command structure or comparable emergency operation organization. The PIO transmits relevant information about public health, safety, and protection as appropriate. The PIO is responsible for media relations and supports public information and warnings by gathering, verifying, coordinating, and disseminating accurate, accessible, and timely information. PIOs handle inquiries from the media, the public, and elected officials.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP4.1a-b At a minimum, evidence must identify the PIO and deputy PIO (necessary for continuity of operations) are responsible for implementing jurisdictional public information and communication strategies. Same or additional evidence must also define the PIO requirements and duties; roles and responsibilities; and required qualifications or skills for PIO personnel. The deputy PIO (or equivalent personnel) must be able to serve as an alternative for the PIO in COOP and other situations. **The PIO and deputy PIO position must be currently filled, even with a temporary or acting person.** The same person cannot fill both primary and deputy roles; however multiple roles can be filled by other incident staff.	Acceptable Evidence • Contact lists, PIO training logs, sign-in sheets, etc. that document PIO specific trainings. • Other documents such as job action sheets that outline requirements and duties; roles and responsibilities; and required qualifications or skillset for the PIO and deputy PIO. • SOP, communication plans, Crisis and Emergency Risk Communication (CERC) Annex job description, job action sheet that identifies roles and responsibilities of a PIO and Deputy PIO (alternative/backup) as key ICS members or comparable emergency operation structure.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP4.2a-c *Joint information system (JIS) process and components include* *a. Integration with emergency management and other NIMS structures,* *b. Process for establishing and participating in a Joint Information Center (JIC), and* *c. Process for identifying a JIC representative.*	JIS facilitate coordination of emergency management during a response. **Function 2:** Determine the need for a JIS. **Task 1:** Coordinate with jurisdictional emergency. management to establish a public health JIC or a virtual JIC and participate in a JIS as needed. **Task 2:** Ensure appropriate participation from public health communications representatives in the jurisdictional EOC. **P1:** Procedures in place to activate a JIC or virtual JIC connecting public information agencies or personnel. **E/T 1:** Minimum components of a virtual JIC. **Function 3:** Establish and participate in information system operations. **P1:** Procedures in place for when the public health agency may designate a lead PIO or provide public information support within emergency operations plans.	JIS are necessary to integrate incident information and public affairs into a cohesive organization to provide coordinated and complete information before, during, and after incidents. JIS help ensure coordinated messaging occurs among all incident personnel. The JIC is a facility established to coordinate all incident-related public information activities. It is the central point of contact for all news media at the scene of the incident. PIOs from all participating agencies generally co-locate in the JIC.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP4.2a Evidence for emergency management and other NIMS structure integration must indicate process for coordination with other activated groups when incidents have a public health component whether in a lead or a supporting role. Evidence must document a process for coordinating messaging across the response when emergencies span multiple agencies within the jurisdiction. The role or process for reviewing of emergency-related messaging must be delineated (e.g., reviewed by lead PIO or similar). **CAP4.2b** Evidence of a process for establishing a JIC must include scalability and nature of the incident. Depending on the nature of the incident, public information sharing must be scalable. Process must include trigger points and decision criteria. **CAP4.2c** Evidence must address plans to staff a JIC. At minimum, evidence must address how the jurisdiction will support JIC staffing.	<u>Acceptable Evidence</u> • Decision flow matrices or algorithms used to determine need for JIS or JIC. • Emergency Support Function (ESF) plans, annexes, standard operating procedures, or communication plans.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP4.3a-c *Procedures in place for crisis and emergency risk communications (CERC) to the public include* *a. Message development,* *b. Message dissemination, and* *c. Process for periodic review of dissemination plan with key community partners.*	Review the process to develop and approve messages during an emergency. **Function 1:** Activate the emergency public information system. **P2:** Message templates and risk communication message development to address identified jurisdictional risks and vulnerabilities related to incident characteristics.	Dissemination of accurate, timely and appropriate information is critical to ensure that targeted, unified public health messages reach all populations in the community. For emergency public information and warning to effectively reach the whole community, engage community partners in message development and dissemination, and review partner roles with the public health department on a repeated basis to ensure competency.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP4.3a Evidence for message development must include a process for reviewing warnings, alerts, directions, and messaging to ensure they are culturally and linguistically appropriate, accessible, and understandable for the whole community. Sole reliance on translation services is not enough to assure the content is meaningfully conveyed. Review demographic data about languages spoken within the jurisdiction. **CAP4.3b** Evidence for message dissemination must describe the process for how community partners are engaged to develop and evaluate messages; disseminate messages including the use of social media; and use partner and stakeholder channels to serve access and functional needs populations. **CAP4.3c** Evidence must document that partners are engaged periodically to review preparedness plans for communication and confirm partner roles prior to, during, and after an incident. Coordination with community partners must be documented but does not need to identify every partner (crosswalk specific evidence of partner involvement with the PPS1b, d, f).	Acceptable Evidence • **At least two examples (required)** documenting the development and dissemination of public health materials that are culturally appropriate, in other languages, or address specific populations that may have difficulty with the receipt or understanding of public health communications. Evidence that exemplifies partner engagement is encouraged. • SOP, communications plans, annex, and pre-developed fact sheet templates, media kits, press release templates, flyers, brochures, or videos.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP4.4a-b *Process or procedures in place to address inquiries about an incident from the* *a. Public, and* *b. Media.*	Identify process for communication with media and the public. **Function 4:** Establish avenues for public interaction and information exchange. **Task 1:** Establish systems for managing public and media inquiries. **P1:** Procedures in place to activate and manage designated inquiry line/s as applicable.	Written procedures and protocols for communication with the public and media ensure consistency in the management of communications on public health issues. Such measures also ensure that the information is in an appropriate format to reach target sectors or audiences. Health departments should answer information requests in a timely and appropriate fashion and obtain appropriate reviews and approvals of information they disseminate.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP4.4a-b Evidence must document the process for working with inquiries from the public including process for triaging and responding to inquiries that become more frequent as a result of incident. Evidence must also document the process for engaging with various types of media, including social media and the press.	Acceptable Evidence • CERC plan, risk communications plan or annex, SOP or SOG, public information announcement examples, documentation of hotline numbers, email addresses, contact information, or social media accounts.	At a minimum, review annually and update as necessary; validate at least every three years.

Capability 5: Fatality Management

Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health

Definition

Fatality management is the ability to coordinate with organizations and agencies to provide fatality management services. The public health agency role in fatality management activities may include supporting

- Recovery and preservation of remains,
- Identification of the deceased,
- Determination of cause and manner of death,
- Release of remains to an authorized individual, and
- Provision of mental/behavioral health assistance for the grieving.

The role may also include supporting activities for the identification, collection, documentation, retrieval, and transportation of human remains, personal effects, and evidence to the examination location or incident morgue.

Element	Purpose	Significance
CAP5.1a-f *During a mass fatality incident describe public health's role for* *a. Electronic death registration system (EDRS) reporting (select lead, support, or no role),* *b. Issuance of death certificates (select lead, support, or no role),* *c. Identification of triggers that prompt public health engagement or activation,* *d. Identification of sites for interim storage and disposition of human remains (select lead, support, or no role), and* *e. Personal protective equipment (PPE) training for medical examiner/coroner (ME/C) fatality management (select lead, support, or no role).* *f. Implementing a tracking system for the identification of recovered remains (select lead, support, or no role).*	Review public health's role in fatality management. **Capability 5, Function 1:** Determine public health role in fatality management. **P2: (Priority)** Definition of the jurisdictional public health agency role for fatality management, established in coordination with jurisdictional authorities, subject matter experts, and other cross-disciplinary stakeholders. **Function 2:** Identify and facilitate access to public health resources to support fatality management operations. **P2: (Priority)** Procedures in place to identify and support public health agency lead or support activities for fatality incident management, including continuity of operations, based on incident data and recommendations. In an incident with multiple fatalities, the ME/C will require the support of several local agencies like emergency medical services (EMS), law enforcement, hospitals, and morticians and funeral directors. In addition, the ME/C may enlist the support from state and federal Disaster Mortuary Response Teams (DMORT), the American Red Cross, and other supporting public and private organizations like public health preparedness, behavioral health, vital statistics and environmental health programs.	Understanding the role of public health and the responsibilities of partners handling mass casualties facilitates fatality management coordination. The role of public health in fatality management varies across jurisdictions.

Reviewer Guidance	Required Documentation	Submission Frequency
Evidence must document the lead agency, public health or not, and substantiate the roles and responsibilities for each sub-element. **CAP5.1a:** Evidence must document there is an existing EDRS in place that accommodates cross-agency collaboration and information sharing for mortality data. Transmission of death certificate data to relevant federal agencies must include a field for cause of death. **CAP5.1b** Evidence must document the process for issuing death certificates during a mass fatality and must specify how the information is conveyed to the family and other pertinent parties. See also CAP5.3b. **CAP5.1c** Evidence must define what triggers public health support for incidents with multiple fatalities. Defined triggers must address activations for surge considerations based on type of incident and exposures. Examples of fatality management requiring public health involvement include activation for a pandemic and infectious disease outbreak such as Ebola, and non-infectious disease outbreaks such as e-cigarette or vaping product use-associated lung injury (EVALI). **CAP5.1d** Evidence must document plans for storage and processing of human remains. Plans must outline authority to order, purchase, or provide medical supplies required to process human remains such as disaster pouches or body bags, and medical supplies to conduct forensic analyses. Evidence must document plans to identify and request additional storage for human remains from state, regional, or federal DMORT assets. **CAP5.1e** Evidence must describe process to provide evidence-based recommendations and training for PPE to ME/C, funeral homes, morgue operators, and others regarding incident-specific exposures and infection control practices. Training evidence must document guidance regarding proper PPE use for likely exposures, infection control precautions, and environmental disinfection. **CAP5.1f** Evidence must document engagement of agencies that support local authorities' collection of antemortem data.	Acceptable Evidence Evidence is required for all subelements, regardless of public health's role, to assure public health preparedness programs understand how the jurisdiction structure supports these elements. • Budget line items; purchase orders for supplies or similar • Data use agreements. • ESF-8 hazards plan/annexes; mass fatality plans/ annexes; operations response plan; COOP plans/ annexes; pandemic influenza plan; catastrophic incident plan/annexes. • Evidence of engaged personnel and agencies that support antemortem activities. • Mortality protocols. • MOUs/MOAs, informal agreements with lead agencies or comparable documents. • Victim/missing persons protocols.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP5.2a-f *Fatality management operation plans include* *a. Partner communication,* *b. Surveillance (select lead, support, or no role),* *c. Mortality reporting (select lead, support, or no role),* *d. Supplies (select lead, support, or no role),* *e. Family call/assistance centers (select lead, support, or no role), and* *f. Behavioral/ Mental health services (select lead, support, or no role).*	Identify health departments' ability to coordinate with identified stakeholders to operationalize strategies, as defined in the jurisdictional fatality management procedures, and share incident recommendations for managing human remains. **Function 2:** Identify and facilitate access to public health resources to support fatality management operations. **Task 1:** Assess incident data. **Task 2:** Develop and share incident-specific public health fatality management recommendations. **P2: (Priority)** Procedures in place to identify and support public health agency lead or support activities for fatality incident management, including continuity of operations, based on incident data and recommendations. Activities may include • Mass fatality incident operations, • Communication and guidance activities, and • Community resilience and support. **Function 4:** Support the provision of survivor mental/behavioral health services. **P1: (Priority)** Procedures in place to identify, develop, and implement services for survivors, families, and responders in conjunction with jurisdictional mental/behavioral health partners. **Function 5:** Support fatality processing and storage operations. **P2:** Procedures in place for timely electronic death reporting in medical examiner or coroner case management systems or electronic death registration systems for information sharing.	Public health should establish plans for fatality management in accordance with jurisdictional operational roles and responsibilities. The role of public health in fatality management operations varies across jurisdictions.

Reviewer Guidance	Required Documentation	Submission Frequency
Evidence must document the lead agency, public health or other, and substantiate public health understanding of the roles and responsibilities for each sub-element. **CAP5.2a** At a minimum, evidence of partner communication must document plans for situational awareness and information sharing. Mortality tracking, surveillance, and reporting must be included as evidence of the communication pathway. **CAP5.2b** Mortality may be indirectly related to natural disasters, severe weather, or human-induced events. In some instances, chronic conditions may be exacerbated by an acute event. Evidence for mortality surveillance must address both infectious and non-infectious disease reporting. Evidence must also document case definition protocols and reporting. **CAP5.2c** Mortality reporting documentation must describe information exchange between local, state, emergency managers, and the ME/C. Report protocols must describe the adjudication process for determining final mortality counts and cause of death determinations prior to reporting to vital statistics. See *A Reference Guide for Certification of Deaths in the Event of a Natural, Human-induced, or Chemical/Radiological Disaster* and *Death Scene Investigation Toolkit*. **CAP5.2d** Evidence must describe process for requesting material and coordination of supplies to support the processing of human remains such as body bags, and PPE. Consideration of supplies necessary to safeguard management of remains associated with an infectious, highly pathogenic, or another hazardous agent should also be documented. **CAP5.2e** Evidence must document the health department has a 24/7 emergency contact number or can activate a scalable call center to handle inquiries, missing persons reports, and family assistance after a large-scale emergency. Evidence must also document the protocols to activate family assistance centers to address immediate surge needs and long-term family management support. **CAP5.2f** At minimum, evidence must demonstrate the jurisdiction maintains a resource list for mental/behavioral health outreach services and documents the process to coordinate assembly of trained mental/behavioral health teams to serve the impacted population including victims, families, and first responders. See also CAP2.1c, e).	Acceptable Evidence • ESF-8 hazards plans/annexes; mass fatality plan/annex; operations response plans; COOP plans/annexes. • MOUs/MOAs, informal agreements with lead agencies, or comparable documents. • Mortality reporting surveillance protocols.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP5.3a-c *Plans for antemortem data describe* *a. Victim identification data collection, methods (select lead, support, or no role),* *b. Family notification (select lead, support, or no role), and* *c. Dissemination (select lead, support, or no role).*	Assess the health departments' ability to assist lead authorities and other partners to gather necessary resources and disseminate information to partners and impacted individuals within jurisdictions. **Function 3:** Assist in the collection and dissemination of antemortem data. **Task 1:** Establish and refine antemortem data management processes. **P1: (Priority)** Procedures in place to collect and handle antemortem data in a secure and confidential manner, including data collection and dissemination methods. **P2:** Procedures in place for family notification, depending upon public health agency fatality management lead or support role.	State and local health departments may be responsible for processing, providing and maintaining death records. This element ensures agencies can coordinate fatality management plans, services, and infrastructure with appropriate stakeholders.

Reviewer Guidance	Required Documentation	Submission Frequency
Evidence must document the lead agency, public health or not, and substantiate the roles and responsibilities for each sub-element. **CAP5.3a** To facilitate victim identification, evidence must document antemortem repositories and include appropriate equipment and technology for data management. Protocols must document pre-identified variables for data collection, storage, and reporting of antemortem and postmortem information into a centralized repository/ database . See also CAP5.1f. **CAP5.3b** Evidence must document procedures for family notification. Procedures must be defined for interaction with family, including next of kin, in any manner of death. Information must be available in multiple formats including verbal, written, and available in languages commonly spoken within the jurisdiction. **CAP5.3c** Evidence must document plans for dissemination of antemortem data to partners for situational awareness. Plans must also document available antemortem resources from the agency if requested.	Acceptable Evidence Evidence is required for all sub-elements, regardless of public health's role, to assure public health preparedness programs understand how the jurisdiction structure supports these elements. • **CAP5.3b:** Family assistance center annex or module; family services operations annex; national advocacy/ support programs and resource lists; notification and referral group process or template. • ESF-8 hazards plans/annexes; mass fatality plans/ annexes; operations response plan; COOP plans/ annexes; concept of operations (CONOPS) plans. • Legal authorities. • MOUs/MOAs, informal agreements with lead agencies, or comparable documents. • Surveillance protocols; data use agreements.	At a minimum, review annually and update as necessary; validate at least every three years.

Capability 6: Information Sharing

Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health

Definition

Information sharing is the ability to conduct multijurisdictional and multidisciplinary exchange of health-related information and situational awareness data among federal, state, local, territorial, and tribal levels of government and the private sector. This capability includes the routine sharing of information, as well as issuing of public health alerts to all levels of government and the private sector in preparation for, and in response to, events or incidents of public health significance.

Element	Purpose	Significance
CAP6.1a-b *Plans for partner information exchange include* *a. Partner engagement and* *b. Communication platform.*	Address the health department's plan for coordination, collaboration and integration of information sharing between agencies to ensure a multi-disciplinary approach. **Capability 6, Function 1:** Identify stakeholders that should be incorporated into information flow and define information sharing needs. **Task 1:** Identify intra- and interjurisdictional stakeholders. **Task 2:** Update and refine information sharing needs. **P1: (Priority)** Roster of identified stakeholders to engage for bi-directional information exchange. **Function 2:** Identify and develop guidance, standards and systems for information exchange. **P5: (Priority)** Written agreements with relevant agencies and other stakeholders to define participation, security or access levels, and procedures for information exchange. **P6: (Priority)** Procedures in place to account for laws, provisions, and policies addressing privacy, security including cybersecurity, civil liberties, and other substantive issues. **Function 3:** Exchange information to determine a common operating picture. **E/T3: (Priority)** Secondary systems for information sharing and public health alerting in case primary system is unavailable.	An effective plan for information and data sharing increases the capacity of public health agencies to electronically exchange accurate health data and information from a variety of sources during incidents. Access to timely, relevant information flow is critical to incident partners' ability to understand the current situation and take appropriate actions.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP6.1a Partner engagement must be evident with key stakeholders. Review partner lists for stakeholders that engage in bidirectional information sharing. At a minimum, partners must include emergency management, emergency responders such as fire, police, and EMS, environmental health agencies, and area/regional health agencies. Information is shared to maintain situational awareness prior to public health incidents, during operational communications, and to coordinate response. **CAP 6.1b** Communication platform evidence must include at least one backup system for communicating with partners in the event of power loss or other communication disruption; evidence of periodic testing through a drill or incident is required.	Acceptable Evidence • Examples of evidence during operational communications might include situation reports, aggregated surveillance reports, or incident action plans. • Examples of evidence prior to an incident might include updates from partners. • Examples of evidence to coordinate a response might include mission tasks, outcome monitoring, resource requests, tracking, or specific situation status reports. • Rosters, annexes with listed partners and affiliations, contact information, situational awareness briefings, safety plans, responder alert plans, communications radio plans, incident radio communications plan (ICS 205), or communications phone list. • SOP, written agreements, or communication plans.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP6.2a-c *Plans in place for information sharing support situational awareness and education and include* *a. Content and development,* *b. Dissemination, and* *c. Secure messaging.*	Established systems in place to share information across public health, other agencies, and stakeholders using national standards such as data vocabulary, storage, transport, security, and accessibility standards. **Function 3:** Exchange information to determine a common operating picture. **Task 1:** Exchange health information. **P1: (Priority)** Procedures in place to develop information and public health alert messages. **P5:** Templates for public health alert messages and procedures including distribution methods to ensure messages reach intended individuals 24/7 year-round.	A critical component of public health and emergency management plans is identifying a common operating picture for effective information exchange among intra-and inter- jurisdictional stakeholders, information sources, and those impacted by an incident/ event. A public health alert network (HAN) can provide timely and accurate messaging to stakeholders about urgent public health incidents. Communicating effectively and adapting content that addresses the needs of the whole community is integral to minimizing morbidity and mortality.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP6.2a Evidence must document process for developing message content and approving public health alert messages. **CAP6.2b** Evidence must document how information is disseminated including responding to requests for information. **CAP6.2c** Evidence must include processes for how partners receive information in a timely and secure manner. Evidence for secure messaging must document the use of standards for information exchange. Use of applicable security levels such as sensitive, but unclassified, confidential, etc. are **acceptable evidence**. Evidence must describe how as an incident grows in scale, increasing number of partners are incorporated into the information flow. Lists of personnel authorized to share and receive information, data use and release parameters, legal and statutory or intellectual property regulations are sufficient evidence. Safeguards for the exchange of information must consider the who, what, where, when and why.	Acceptable Evidence • Evidence that alerts are sent based on roles, organizations, or locations. • HAN or similar web-based notification system used to alert intra- and inter- agency partners with situational awareness of conditions. • SOP, agreements, plans, or annexes. • Templates for health care providers, community, or other identified partners.	At a minimum, review annually and update as necessary; validate at least every three years.

Capability 7: Mass Care

Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health

Definition

Mass care is the ability of public health agencies to coordinate with and support partner agencies to address, within a congregate location (excluding shelter-in-place locations), the public health, health care, mental/behavioral health, and human services needs of those impacted by an incident. This capability includes coordinating ongoing surveillance and assessments to ensure that health needs continue to be met as the incident evolves.

Element	Purpose	Significance
CAP7.1a-g *Plans describe public health roles and responsibilities related to mass care within congregate sites such as shelters* *a. Food safety (select lead, support, or no role),* *b. Water safety (select lead, support, or no role),* *c. Facility sanitation (select lead, support, or no role),* *d. Climate monitoring (select lead, support, or no role),* *e. Waste management (select lead, support, or no role),* *f. Health care services (select lead, support, or no role), and* *g. Mental/behavioral health services (select lead, support, or no role).*	The mass care leads as defined in ESF-6 are Department of Homeland Security (DHS), Federal Emergency Management Agency (FEMA), and the American Red Cross. Public health responsibilities vary across jurisdictions. This element reviews public health roles and responsibilities in lead or support of various public health-related roles. **Capability 7, Function 1:** Determine public health role in mass care operations. **P1: (Priority)** Procedures in place to coordinate with ESF-6, ESF-8, and ESF-11 partners, including emergency management, environmental health, and other agencies, to identify the jurisdictional public health agency lead or support role(s). **Function 2:** Determine mass care health needs of the impacted population. **Task 2:** Assess congregate locations. **Task 3:** Ensure food and water safety at congregate locations. **Function 3:** Coordinate public health, health care and mental/behavioral health services. **P1: (Priority)** Written agreements, such as contracts or MOUs, with organizations that support the provision of medication and administration of vaccines.	The role of public health in mass care and shelter services involve agencies and organizations across local and state levels, nonprofit and faith-based organizations, and the private sector. A clear delineation of partner roles and responsibilities before an incident clarifies collaboration and facilitates efficient operational coordination during an incident.

Reviewer Guidance	Required Documentation	Submission Frequency
Evidence must document the lead agency, public health or not, and substantiate the roles and responsibilities for each sub-element. **CAP7.1a** Evidence must document food safety plans and applicable food service inspections. Roles and responsibilities for managing food at congregate sites must be included. **CAP7.1b** Evidence must document water safety plans including roles and responsibilities for management at congregate sites. Evidence of plans for securing or providing potable water must also be documented. **CAP7.1c** Evidence must document sanitation plans including roles and responsibilities for maintaining general sanitation at congregate sites. **CAP7.1d** Evidence must document the plans, roles, and responsibilities for monitoring ventilation and temperatures at congregate sites. **CAP7.1e** Evidence must document plans, roles, and responsibilities for waste management at congregate sites. **CAP7.1f** Evidence must document plans for the provision of acute health care services to shelter populations; plans must address how medication/vaccines will be secured, transported, and distributed to the shelter and other congregate sites. Evidence must also document procedures, trainings, and resources to support the use of immunization information systems (IIS) at congregate sites to assess immunization status (as applicable) and document any immunizations administered. See also CAP9.5a-c & CAP10.3e. **CAP7.1g** Evidence must document the plans for monitoring medical and mental/behavioral health needs for evacuees, including those at congregate sites . See also CAP2.1c-e.	<u>Acceptable Evidence</u> Evidence is required for all sub-elements, regardless of public health's role, to assure public health preparedness programs understand how the jurisdiction structure supports these elements. • ESF-8 hazards plans/annexes; mass care plans/annexes; operations response plans; CONOPS plans/ annexes; environmental health plans/annexes; or MOUs/MOAs, informal agreements with lead agencies, or comparable documents.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP7.2 *Plans or process for accommodating populations with access and functional needs (AFN) at congregate locations.*	Identify role for supporting AFN within congregate sites in coordination with ESF-6 partners. ESF-8 role includes providing subject matter expertise and technical assistance as part of mass care role during a disaster response. **Function 1:** Determine public health role in mass care operations. **Function 3:** Coordinate public health, health care, and mental/behavioral health services. **P3: (Priority)** General population shelters that accommodate families with children, persons with disabilities, and those with AFN, and procedures to transfer individuals from general shelters to specialized shelters or medical facilities.	Shelters must be physically accessible and equipped with assets and resources necessary to ensure whole community access. Support for individuals with disabilities and others with chronic or acute access and functional needs must be anticipated. Include experts on disabilities, accessibility, and inclusion to provide insight about accommodations that might otherwise be overlooked during congregant site planning.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP7.2 Evidence must document public health plans for coordinating support to individuals with disabilities and AFN population at congregate sites, including assuring facility accessibility. Plans must include a process for coordination with applicable providers to integrate the delivery of human services and necessary medication and devices at congregate sites.	Acceptable Evidence • ESF-8 hazards plans/annexes; mass care plans/annexes; operations response plan; CONOPS plans/annexes; environmental health plans/annexes; and MOUs/MOAs; shelter plans/annexes informal agreements with lead agencies, or comparable documents.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP7.3 *Plans describe the process for conducting human health surveillance at congregate locations.*	Review congregate site plans for health monitoring during a response. **Function 4:** Monitor mass care population health. **P1: (Priority)** Procedures in place to conduct ongoing shelter population health surveillance. **P2: (Priority)** Templates for disaster-surveillance forms, including active surveillance and facility 24-hour report forms.	Mass care includes conducting health surveillance and assessment for shelter populations. Active surveillance and assessment identify needs of those impacted by an incident and facilitates the continued monitoring of the public's health while in congregate settings.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP7.3 Evidence must document the plans for population monitoring/surveillance within congregate sites including general, medical, and alternate care sites. Documented procedures must cover thresholds for surveillance activities and procedures for contacting public health representatives in case of a mass care; see also CAP10.3b.	Acceptable Evidence • ESF-6 or ESF-8 hazards plans/annexes; mass care plans/annexes; operations response plans; CONOPS plans/annexes; shelter plans/annexes. • Surveillance protocols, or disaster surveillance forms or templates.	At a minimum, review annually and update as necessary; validate at least every three years.

Capability 8: Medical Countermeasure Dispensing and Administration

Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health

Definition

Medical countermeasure dispensing and administration is the ability to provide medical countermeasures to targeted population(s) to prevent, mitigate, or treat the adverse health effects of a public health incident, according to public health guidelines. This capability focuses on dispensing and administering medical countermeasures, such as vaccines, antiviral drugs, antibiotics, and antitoxins.

Element	Purpose	Significance
CAP8.1a-d *Process to request assistance for medical countermeasures (MCM) assets involving* *a. Federal disaster declaration,* *b. No federal disaster declaration (possible state declaration),* *c. Isolated, individual, or time-critical to the jurisdiction, and* *d. Coordination with tribal governments (if applicable).*	Adequate medicines and supplies available for dispensing can help save the lives of those who may need them the most during a public health emergency. When there are not enough local supplies, a process to request MCM assets from the state is critical. **Capability 8, Function 2:** Receive MCM to be dispensed/ administered. **P1: (Priority)** Procedures in place to assess MCM inventories and determine the need for additional medical countermeasures. **P2: (Priority)** Procedures in place to request, order, and receive MCMs at dispensing/ administration sites, as applicable, in accordance with guidelines. **P3: (Priority)** Procedures in place for the storage and handling of MCMs at dispensing/administration sites.	MCMs as defined by PHEP are life-saving medicines and medical supplies that can be used to prevent, mitigate, or treat adverse health effects of a public health incident associated with chemical, biological, radiological, or nuclear (CBRN) threats, emerging infectious diseases, or a natural disaster.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP8.1a Evidence must document the process to request MCM assistance during a federal disaster declaration. The process for requests must adhere to the relevant jurisdictional hierarchy, such as local-to-state or state-to-federal, and must define triggers to justify a request, methodology for dispensation, and authority to approve. **CAP8.1b** Evidence must document the process to request MCM assistance **in the absence** of a federal disaster declaration. The process for requests must adhere to the relevant jurisdictional hierarchy, such as local-to-state or state-to-federal, and must define triggers to justify a request, methodology for dispensation, and authority to approve. One protocol that adequately addresses requesting MCM both during a federal declaration versus no federal declaration is acceptable. **CAP8.1c** For an isolated, individual, or time-critical issue specific to the jurisdiction, the evidence must document the process to request MCM assistance and adhere to the relevant jurisdictional hierarchy (local-to-state or state-to-federal). Evidence must define triggers to justify a request, methodology for dispensation, and authority to approve. **CAP8.1d** There are 574 federally recognized tribes in 35 states. Review evidence from states with federally recognized tribes. Evidence must address the process for federally recognized tribes to request MCMs and plans must document 1) coordination with the local, state, or federal authority, 2) triggers to initiate a request, 3) methodology for dispensation, and 4) approval authority. Jurisdictions with tribes only recognized by states with such authority (and not at the federal level) are encouraged to document plans with the same components. **States with federally recognized tribes:** Alabama | Alaska | Arizona | California | Colorado | Connecticut | Florida | Idaho | Indiana | Iowa | Kansas | Louisiana | Maine | Massachusetts | Michigan | Minnesota | Mississippi | Montana | Nebraska | Nevada | New Mexico | New York | North Carolina | North Dakota | Oklahoma | Oregon | Rhode Island | South Carolina | South Dakota | Texas | Utah | Virginia | Washington | Wisconsin | Wyoming	Acceptable Evidence • Signed plans/annexes or SOPs with each process including tribal coordination if applicable.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP8.2 *POD security plans in place*	Adequate security planning is essential to safeguard dispensed or administered MCM, POD staff and visitors, and sustainability of operations. **Function 3:** Activate MCM dispensing/administration operations. **P1: (Priority)** Procedures in place to guide the activation of dispensing/administration sites and the activation of trained personnel, volunteers, and skilled personnel to support those sites. **P2: (Priority)** Procedures in place to dispense/administer MCMs to public health responders and critical workforce either pre-incident or during the early stages of an incident. **P3: (Priority)** Security measures, specific to each MCM dispensing and vaccine administration site, as necessary, to ensure personnel safety, product security, and crowd management during an incident .	The goal of a POD is to efficiently provide MCM to a large population in a short period of time. POD locations should be both familiar and easily accessible to the community. Effective security plans are necessary to protect the public, personnel, and dispensed/administered MCMs.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP8.2 POD security must be planned to meet the specific needs of the location and facility. Evidence must address exterior and interior security, evacuation procedures, breach procedures, and scalability at a minimum. Good POD security plans must address the following components of safety: **Exterior security:** Document any specialized unit needs, canine explosive ordinance disposal, unit barriers, additional lighting, staging areas for people in vehicles, identification of entrances and exits, and external crowd control. **Interior security:** Plan to conduct a security sweep before facility use and identify where security officers or law enforcement will be posted; ensure protocols for crowd control. **Scalability:** Include how POD security is established based on threat levels and judgement from informed partners including security officers, and law enforcement. **Security breach:** Address shelter-in-place and evacuation procedures. Additionally, states must provide evidence that substantiates oversight of POD safety across all local planning jurisdictions. If security plans are created and maintained by law enforcement partners, a trusted agent can verbally affirm to the reviewer that the security plans (or equivalent) adequately address safety considerations for both the exterior and interior of the facility as well as breach procedures in compliance with the submission frequency (validated every three years).	Acceptable Evidence • Documentation of procedures in plans, algorithms, flow charts, checklists, SOPs, or SOGs. • Emergency operations plan; Strategic National Stockpile (SNS) plans; MCM dispensing plans; annexes.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP8.3a-e *Process for dispensing MCM in POD and dispensing vaccination clinics (DVC) sites include* *a. Flow diagram.* *b. Algorithm for dispensing MCMs.* *c. Record/log of drugs dispensed.* *d. Investigational New Drug (IND) protocols, and* *e. Emergency Use Authorization (EUA) protocols*	Provide MCMs to the target population in accordance with public health guidelines and recommendations appropriate to the incident. **Function 4:** Dispense/administer MCMs to targeted population(s). **P1: (Priority)** Procedures in place to dispense/ administer MCMs to affected, targeted, and prioritized populations that align with current science, incident characteristics, and public health guidelines. **P2: (Priority)** Drug or vaccine information available to the public and to persons receiving MCMs. **S/T 1:** Personnel trained on jurisdictional MCM tracking systems, such as immunization information systems, electronic health records, or other tracking databases.	The goal of a POD/DVC is to conveniently provide MCM to a large population in a short period of time. POD/DVC locations should be both familiar and easily accessible to the community. POD planning is necessary to assure effective and efficient MCM dispensing/administration.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP8.3a Evidence must include a clear process for screening and triaging visitors for jurisdictions with open PODs. In addition, states must provide evidence that documents how oversight of local implementation is directed; state provided guidance to local jurisdictions is **acceptable evidence**. **CAP8.3b** Evidence must document an algorithm for dispensing medications or an algorithm for administering vaccinations for all PODs/DVCs. In addition, states must provide evidence that documents how oversight of local implementation is directed; state provided guidance to local jurisdictions is **acceptable evidence**. **CAP8.3c** Evidence must document the process for recording pertinent information about the individual and dispensed product such as individual's name and contact information, drug manufacturer, and lot number for jurisdictions with open PODs. In addition, states must provide evidence that documents how oversight of local implementation is directed; state provided guidance to local jurisdictions is **acceptable evidence**. **CAP8.3d** IND is a regulatory mechanism by which the Federal Drug Administration (FDA) permits access and use of a medical product that has not received FDA-approval and is "investigational" an unapproved "experimental" product or allows a medical product to be used in a way that differs from its approved use. Evidence must document use of informed consent and must comply with FDA's IND protocol including IND recipient monitoring for adverse side effects. States must provide evidence that documents how oversight of local IND implementation is directed; state provided guidance to local jurisdictions is **acceptable evidence**. **CAP8.3e** EUA is a statutory, legal authority of the FDA commissioner to permit the emergency use of an unapproved medical product or unapproved use of an approved medical product to diagnose, treat, or prevent serious or life-threatening diseases or conditions for which no adequate, FDA-approved alternative is available. FDA's issuance of an EUA is predicated on the HHS secretary's declaration of emergency based on threat determination. Evidence must document how MCM under an EUA will be 1) dispensed for up to one year, 2) comply with FDA protocols, and 3) suspended once the EUA is revoked or the HHS emergency declaration is terminated. States must provide evidence that documents how oversight of local EUA implementation is directed; state provided guidance to local jurisdictions is **acceptable evidence**.	Acceptable Evidence • Dispensing log from event or exercise. • Documentation of procedures in plans, algorithms, flow charts, checklists, SOPs, or SOGs. • EOPs; SNS plans; MCM dispensing plans; or annexes. • Informed consent documentation. • Instruction from state to local jurisdictions about IND/EUA.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP8.4 ***MCM procedures for cold chain management.***	Cold chain management is needed to meet storage and handling requirements for specific MCM. **Function 2:** Receive MCMs to be dispensed/administered. **P3: (Priority)** Procedures in place for the storage and handling of medical countermeasures at dispensing/administration sites. May include procedures for cold chain management. **E/T2:** Equipment, supplies, and systems needed to support dispensing/administration, which may include: Primary and backup cold chain management equipment, such as portable, insulated containers for transporting temperature-sensitive medical countermeasures.	Jurisdictions must plan for handling all aspects of products requiring cold chain management. Maintenance of cold chain integrity according to storage and handling guidelines assures MCM efficacy.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP8.4 Jurisdictions must follow CDC vaccine storage and handling guidelines. See also Vaccine Storage and Handling Toolkit. Evidence must document how the jurisdiction will store, handle, and equip dispensing sites (identified as DVC) that require MCM cold chain management in accordance with federal guidelines. Plans must also specifically address procedures beyond storage in the supplied shipping containers to address situations when the inventory cannot be dispensed within the timeframe for which shipping containers can sustain the required storage temperature. Cold chain management procedures must include backup storage options and processes that comply with all regulatory guidance if primary plans or equipment are unavailable or fail.	Acceptable Evidence • Documentation of procedures in plans, algorithms, flow charts, checklists, SOPs, or SOGs. • EOPs; SNS plans; MCM dispensing plans; or annexes.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP8.5a-o *General point-of-dispensing (POD) information* *a. POD name,* *b. POD operation type (open/closed),* *c. POD planning type (primary, backup, tertiary); If jurisdiction doesn't designate POD type, select primary,* *d. Address,* *e. POD used as antibiotic dispensing clinic (y/n),* *f. POD used as dispensing vaccination clinic (y/n), and* *g. Written agreement in place (y/n).* *POD Detail* *h. Type of facility (academic institution, athletic complex, community center, government facility, etc.),* *i. Estimated population who will visit the POD,* *j. Primarily walk through, drive through, combination (select 1),* *k. Staffing is based on a tiered approach (y/n),* *l. Total staff needed for antibiotic dispensing operation,* *m. Total staff currently identified for antibiotic dispensing operation,* *n. Total staff needed for vaccine administration clinic/DVC (if applicable), and* *o. Total staff currently identified for vaccine administration clinic/DVC.*	POD planning should estimate staffing needs for all PODs identified for use in a worst-case scenario in which the entire population requires MCMs. The POD form collects current planning estimates and information about individually designated POD locations, populations served, and staffing necessary to conduct dispensing activities for one shift. At minimum, PODs/DVCs designated for use in a worst-case scenario must be entered. Any POD/DVC (both open and closed) used in an exercise or incident must be documented for alignment with operational submissions. Jurisdictions should also enter information for backup PODs, tertiary PODs, and closed PODs to provide a complete picture of potential PODs within their jurisdictions. **Function 1:** Determine MCM dispensing/administration strategies. **Task 2:** Establish a network of sites. **P4: (Priority)** Network of sites for dispensing/administering MCMs. **Function 2:** Receive MCM to be dispensed/administered. **Task 3:** Receive MCMs at dispensing/administration sites. **P3:** Procedures in place for the storage and handling of MCMs at dispensing/administration sites.	MCM are life-saving medicines and medical supplies that can be used to prevent, mitigate, or treat adverse health effects of a public health incident associated with chemical, biological, radiological, or nuclear (CBRN) threats, emerging infectious diseases, or a natural disaster.

Reviewer Guidance	Required Documentation	Submission Frequency
Review the data for accuracy. **CAP8.5a-o** Jurisdictions must enter all information about primary open PODs and provide evidence of use agreements. The total reported open PODs must align with the estimated number of PODs submitted on the JDS to assure adequate coverage to support an MCM dispensing campaign. Evidence must document the staffing model. It must include all possible staffing sources and options, accounting for staff authorized to dispense antibiotics or administer vaccine, process to request and mobilize staff, use of staging (if applicable), and just-in-time training plans; if needed and identified staff numbers do not align, plans must describe process to ascertain additional staff. If POD plans include potential for vaccine administration (or dispensing vaccine clinic (DVC), evidence must document relevant staff estimates and roles. If a jurisdiction uses a tiered approach instead of rostering staff for all POD positions, there must also be evidence of a matrix or model and sufficient detail about how additional staff will be ascertained given a worst-case scenario. Although not required, it is recommended that jurisdictions also enter information on backup PODs, tertiary PODs, and closed PODs to provide a complete picture of potential PODs within their jurisdictions. Note. TFAS only need to complete the general POD information (not the additional detail).	<u>Acceptable Evidence per POD or Facility</u> • MOUs/MOAs. • POD flow charts (with POD name). • Site-specific POD plans (or equivalent). • Site surveys. • Staffing models, lists. • Use agreement/s with designated facilities.	At a minimum, review annually and update as necessary; validate at least every three years.

Capability 9: Medical Materiel Management and Distribution

Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health

Definition

Medical materiel management and distribution is the ability to acquire, manage, transport, and track medical materiel during a public health incident or event, and the ability to recover and account for unused medical materiel, such as pharmaceuticals, vaccines, gloves, masks, ventilators, or medical equipment after an incident.

Element	Purpose	Significance
CAP9.1 a-e *Transportation plans include* *a. Primary transport,* *b. Backup transport,* *c. Operators,* *d. Jurisdiction's response time for initial transportation requirements, and* *e. Security plan in place.*	Address transportation assets for a jurisdiction. **Capability 9, Function 1:** Assessment of jurisdictional medical materiel needs and distribution response capacity to identify gaps and inform distribution site selection. **P1: (Priority)** Procedures in place to assess MCM inventories and determine the need for additional MCMs. **P2: (Priority)** Jurisdictional plans that reflect the sequential process of medical materiel distribution, meaning acquisition, management, transport, tracking, recovery, disposal, and return or loss. **P3: (Priority)** Identified lead or jurisdictional authority to initiate medical materiel distribution operations based on incident triggers and incident characteristics. **P4: (Priority)** Written agreements, such as contracts or MOUs, with partner and stakeholder organizations to support medical materiel distribution operations. **P5: (Priority)** Primary and back-up distribution sites capable of receiving, staging, storing, and distributing medical materiel, regardless of the originating supply source. **Function 4:** Monitor medical materiel inventories and medical materiel distribution operations **P3: (priority)** Procedures in place to assess ongoing security measures throughout the distribution process and adjust, as necessary.	A robust transportation strategy should identify and document jurisdictional transportation assets and establish procedures to mobilize those assets given the incident characteristics. Transportation plans that address the complex and numerous considerations required to effectively receive and move assets within a jurisdiction is critical during a public health incident or event.

Reviewer Guidance	Required Documentation	Submission Frequency
Evidence must document the local role within state plans for distribution. The evidence must document transport resources (both primary and backup) available for use in a "worst-case" scenario where MCMs must be delivered to all open PODs, hospitals, and treatment centers. The maximum number of vehicles available for use must meet the needs of the defined considerations. If plans include use of private transportation resources versus government-owned vehicles, the evidence must specify the response time for vendors to provide needed transportation assets, for example, private transportation resources will be activated within 12 hours from notice. **CAP9.1a-b** Primary and backup transport plans must indicate how transportation will be procured. Plans must identify roles and responsibilities of primary and backup transport agencies and relevant partners must acknowledge their roles and responsibilities. **CAP9.1c** Evidence must document an adequate number of operators/resources to transport MCMs to all potential sites in a timely manner. Estimates of the needed operators or a list of potential drivers is acceptable. **CAP9.1d** Documentation must include how the estimated time of arrival is calculated, for instance, using GPS maps. Review plans for adjusting estimates given the scale, type, and nature of the incident. For example, a GPS-calculated estimate under typical conditions might need to be adjusted if the incident caused road closures. CAP9.1e If security is not provided by the transportation agency, contracts specifically to safeguard MCM transport are **acceptable evidence**. If security plans are created and maintained by law enforcement partners, including police or private security firms, a trusted agent can verbally affirm to the reviewer that the security plans or equivalent adequately address safety considerations for MCM transport. Evidence must document coordination with tribal nations for jurisdictions with federally recognized tribes.	Acceptable Evidence • MCM/SNS plans or annexes; distribution operations manual; EOs or annexes; or facility plans, security procedures or contracts. • Signed MOAs, MOUs, intergovernmental agreements (IGAs), interagency agreements (IAAs), contracts, or cross-jurisdictional or regional plans.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP9.2a-h Must enter primary and backup RSS facility *a. Primary RSS site name,* *b. Primary RSS address,* *c. Primary date of site validation,* *d. Primary: Adequate RSS staffing available for 24 hours of continuous operation* *e. Backup RSS site name,* *f. Backup RSS address,* *g. Backup date of site validation, and* *h. Backup: Adequate RSS staffing available for 24 hours of continuous operation.*	Provide situational awareness about potential MCM storage facilities and assess RSS staffing. **Function 1:** Direct and activate medical materiel management and distribution. **Task 3:** Establish a network of distribution sites. **P1: (Priority)** Assessment of jurisdictional medical materiel needs and distribution response capacity to identify gaps and inform distribution site selection (number of sites and locations), personnel resource requirements, transportation requirements, inventory management strategies, and security measures. Assessment may include RSS sites, warehousing strategies and logistical support needs for network of distribution sites. **Function 3:** Distribute medical materiel. **P1: (Priority)** Procedures in place to apportion and transport medical materiel. **S/T 1:** Personnel trained to manage and distribute medical materiel in alignment with jurisdictional procedures. Job action sheets for key distribution positions may include distribution lead, logistics lead, receiving site lead(s), security lead, inventory management, and Drug Enforcement Administration (DEA) registrant.	The plans for operating and staffing RSS facilities must be both scalable and flexible to ensure the RSS facility can accommodate a rapid and potentially sustained response. The RSS size, design, demand, shifts and overall operational rhythm will determine staffing types and quantity. Staffing considerations at the RSS should be constant and adequate to sustain 24 hours of continuous operation for the duration of a distribution campaign.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP9.2a, CAP9.2e Evidence must indicate the name of the RSS facility. **CAP9.3b, CAP9.2f** Evidence must document the complete physical address for the facility. **CAP9.2c, CAP9.2g** Evidence must document the most recent RSS site validation date. **CAP9.2d, CAP9.3h** Evidence must at minimum outline RSS staff requirements and duties, roles and responsibilities, and required qualifications or skillset. Staffing plans must meet the needs of a primary facility, at minimum. At least one identified RSS staff must be able to oversee controlled substances and have valid DEA registration number. If necessary, staffing plans can include multiple roles for individuals but there must be accompanying evidence of adequate training or response experience fulfilling each role concurrently. If staffing plans include use of existing warehouse staff, evidence must document such agreement and appropriate training for anticipated roles.	Acceptable Evidence • Contact list of required staff. • Job action sheets or equivalent. • MOU/MOA with warehouse to meet staffing needs. • RSS site survey. • Valid registration for staff with known DEA registration.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP9.3 *Plans include process for requesting medical materiel including decision process, for example, trigger indicators or thresholds.*	Review the process for requesting medical materiel. **Function 2:** Acquire medical materiel from national stockpiles or other supply sources. **P1: (Priority)** Procedures in place to request medical materiel for both initial requests and resupply requests. **P2: (Priority)** Procedures in place to receive, stage, and store medical materiel.	Requesting MCMs often begins at the local level when a situation threatens the health and safety of the community. The need for MCMs might be immediate or identified gradually as the magnitude of the public health emergency unfolds. Management of local MCM inventory facilitates an understanding about when supplies may be insufficient to meet the anticipated demand and necessitate a request for state and federal assets.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP9.3 Evidence for decision process must include triggers, indicators, and other strategies and procedures used by the jurisdiction to initiate request for MCMs. The process for requests must adhere to the relevant jurisdictional hierarchy (local-to-state or state-to-federal) and must define triggers to justify a request, methodology for dispensation, and authority to approve. The process for requests must also address agreements made with tribes, if applicable.	Acceptable Evidence • MCM/SNS plans or annexes; distribution operations manuals; EOPs or annexes; or request protocols; request process charts, or equivalent.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP9.4a-c *RSS site-specific security for MCM assets* *a. Security lead during a public health emergency response,* *b. Security plan, and* *c. Regional distribution site (RDS) or local distribution site (LDS), if applicable, and site-specific security plans.*	Review RSS site-specific security. **Function 2:** Acquire medical materiel from national stockpiles or other supply sources **P2: (Priority)** Procedures in place to receive, stage, and store medical materiel; Security measures, including personnel, physical security, and other security measures **Function 4:** Monitor medical materiel inventories and medical materiel distribution operations. **P3: (Priority)** Procedures in place to assess ongoing security measures throughout the distribution process and adjust, as necessary.	Adequate RSS planning is essential to safeguarding RSS staff, sustainability of operations, and for received, staged, and stored MCM.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP9.4a Evidence must document the RSS security lead during an activation. The lead, if not the health department or warehouse security, might be local or state police or a national guard officer (or equivalent). **CAP9.4b** A valid security plan must be available. If security plans are created and maintained by law enforcement partners, a trusted agent, generally the U.S. marshal, can verbally or in writing affirm to the reviewer that the security plans (or equivalent) adequately address safety considerations for both the exterior and interior of the facility as well as breach procedures. **CAP9.4c** If RDS/LDS sites are part of the distribution plans, evidence must document the security lead when different than the RSS security lead during an activation. A valid security plan must be available. If security plans are created and maintained by law enforcement partners, a trusted agent, generally the U.S. marshal, can verbally or in writing affirm to the reviewer that the security plans or equivalent adequately address safety considerations for both the exterior and interior of the facility as well as breach procedures.	Acceptable Evidence • Evacuation plans; or emergency evacuation procedures, or equivalent. • MCM/SNS plans or annexes; distribution operations manuals; EOPs or annexes; or facility plans, security procedures, or equivalent.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP9.5a-c *Allocation and distribution plans address* *a. Chain of custody,* *b. Delivery locations, and* *c. Allocation of limited materiel.*	Review the process and elements of allocation and distribution of materiel and assets. **Function 3:** Distribute medical materiel. **P1: (Priority)** Procedures in place to apportion and transport medical materiel, which may include delivery locations and routes and respective roles and responsibilities of public health agencies, transportation partners, and other relevant entities.	Specific accounting for all MCMs is critical during an incident. Allocation and distribution of medical materiel to receiving sites require specific procedures to properly apportion and maintain materiel integrity.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP9.5a Evidence must document the process for chain of custody and how it is maintained throughout the distribution and dispensing/administration cycle. **CAP9.5b** Evidence must document the locations of all open and closed PODs, hospitals, and as applicable, RDS/LDS sites. **CAP9.5c** Evidence must describe the process for allocating and targeting appropriate sub-populations when MCMs are limited. Evidence must also specifically describe the process for vaccinating critical workforce groups in accordance with CDC guidance for a pandemic scenario.	Acceptable Evidence • Allocation templates or equivalent. • Chain of custody forms or plans or equivalent. • MCM/SNS plans or annexes; mass vaccination plans or annexes; influenza plans or annexes; EOPs; distribution plans or annexes; or inventory management manuals or equivalent.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP9.6a-c *RSS procedures for cold chain management include* *a. Transportation requirements,* *b. Storage requirements, and* *c. Backup storage.*	Review and ensure MCM cold chain management procedures are maintained during receipt, staging, and storage. **Function 1:** Procedures in place to dispense/administer MCMs to public health responders and critical workforce either pre-incident or during the early stages of an incident. **P5 (priority):** Primary and backup distribution sites capable of receiving, staging, storing, and distributing medical materiel, regardless of the originating supply source. **P6:** A transportation strategy that may include cold chain management and other environmental control management requirements, such as humidity requirements; and ability of vendor/s to meet storage and handling requirements, such as cold chain management. **Function 2:** Acquire medical materiel from national stockpiles or other supply sources. **P2 (priority):** Procedures in place to receive, stage, and store medical materiel. Procedures may include maintenance of cold chain integrity according to storage and handling guidelines.	Jurisdictions must plan for receiving, staging, and storing products requiring cold chain management. Maintenance of cold chain integrity according to storage and handling guidelines assures MCM efficacy.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP9.6a The evidence must document that transport resources, both primary and backup, can maintain proper cold chain management in accordance with CDC vaccine storage and handling guidelines. See also Vaccine Storage and Handling Toolkit, section 6. Vaccines must be stored properly from the time they are manufactured until they are administered. Cold chain begins with the cold storage unit at the manufacturing plant, extends to the transport and delivery of the vaccine and correct storage at the provider facility, and ends with administration of the vaccine to the patient. Cold chain evidence must describe the process necessary to monitor and maintain appropriate temperature controls throughout the transportation process. **CAP9.6b-c** Jurisdictions must follow CDC vaccine storage and handling guidelines and checklist. See also Vaccine Storage and Handling Toolkit. Evidence must document how the jurisdiction will store, handle, and equip RSS sites that require MCM cold chain management in accordance with federal guidelines. Plans must also specifically address procedures beyond storage in the supplied shipping containers to address situations when the inventory cannot be distributed within the timeframe for which shipping containers can sustain the required storage temperature. Cold chain management procedures must include backup storage options, should primary facilities experience failures, and processes that comply with all regulatory guidance if primary plans or equipment are unavailable or fail.	Acceptable Evidence • MCM/SNS plans or annexes; EOPs; distribution plans or annexes; or inventory management manuals, cold chain management plans, or equivalent.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP9.7a-b *Recovery and demobilization elements include* *a. Recovery of durable medical equipment and* *b. Recovery of materiel.*	Review recovery and demobilization procedures of equipment and materiel. **Function 5:** Recover medical materiel and demobilize distribution operations. **P1: (Priority)** Procedures in place to demobilize operations, including the release of personnel, closure of distribution sites, recovery of unused medical materiel, and disposal of biomedical waste, according to laws and regulations and in coordination with the health care system and the jurisdictional emergency management agency, as required.	Recovery of durable medical equipment and other reusable materiel occurs during the demobilization/recovery phase. Recovery and demobilization of distribution operations must be based on the characteristics of the incident and in accordance with jurisdictional polices and federal regulations. Plans for disbandment activities should be coordinated with relevant partners well before entering the recovery phase of the response.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP9.7a-b Evidence for the recovery of applicable durable medical equipment and materiel must identify responsible personnel, describe the process, and outline assets needed, such as like vehicles, for recovery of durable medical equipment and MCMs. Evidence must also document where reusable durable medical equipment and remaining MCMs will properly be stored, for example, the primary RSS facility.	Acceptable Evidence • MCM/SNS plans or annexes; EOPs; distribution plans or annexes; or inventory management manuals or equivalent.	At a minimum, review annually and update as necessary; validate at least every three years.

Capability 10: Medical Surge

Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health

Definition

Medical surge is the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of the health care system to endure a hazard impact, maintain or rapidly recover operations that were compromised, and support the delivery of medical care and associated public health services, including disease surveillance, epidemiological inquiry, laboratory diagnostic services, and environmental health assessments.

Element	Purpose	Significance
CAP10.1a-b *Public health medical surge plans during an incident include* *a. Triggers for additional public health support of health care and* *b. Provision for staff to support clinical/medical operations (select lead, support, or no role).*	Review plans for supporting medical surge during an incident that exceeds the limits of routine medical infrastructure and health care systems. **Capability 10, Function 1:** Assess the nature and scope of the incident. **Task 1:** Define the role of the public health agency in medical surge. **Task 2:** Evaluate the structural needs of the jurisdictional incident management system. **P1: (Priority)** Personnel trained and assigned to fill public health incident management roles, as applicable, to a medical surge response to include EOC staffing. **Function 2:** Support activation of medical surge. **Task 1:** Mobilize medical surge personnel. Support mobilization of incident-specific medical and mental/behavioral treatment personnel, public health personnel, and support personnel. **Task 3:** Support additional health care services. Assist with the surge of the health care system through coordination with HCCs, including hospitals and other clinical entities. **P1: (Priority)** Procedures in place that indicate how the jurisdictional public health agency will access volunteer resources through Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), MRC health professional volunteer entities, such as the National Voluntary Organizations Active in Disasters (NVOAD), and other personnel resources. **Function 3:** Support jurisdictional medical surge operations. **Task 2:** Coordinate with partners to provide required resources. **P4: (Priority)** Public health and health care system coordination procedures that account for public health and medical materiel management, inventory assessments, and personnel and equipment resource requests from jurisdictional and other ESF #8 partners as the incident evolves.	Public health must coordinate with ESF-8 partners to determine incident needs around access to medical resources. Public health support for clinicians or other medical surge resources varies across jurisdictions during an emergency that exceeds typical capacity. In some instances, public health might augment services to support emergency response.

Reviewer Guidance	Required Documentation	Submission Frequency
Evidence must document the lead agency, public health or other, and substantiate public health understanding of the roles and responsibilities for each sub-element. **CAP10.1a** Evidence must document what triggers public health support for incidents causing a surge beyond routine medical system capacity. Plans must address how the initial needs and availability of resources, including personnel and facilities, will be ascertained and shared with health care organizations or coalitions. **CAP10.1b** Evidence must document plans to mobilize staff to augment medical, mental/behavioral, public health, and support personnel given the incident-specific needs. Plans must also address staffing temporary treatment centers/shelters for people impacted by an incident. See also CAP15.	Acceptable Evidence • ESF-8 hazards plans/annexes; mass fatality plans/annexes; EOPs; COOP plans or annexes; pandemic influenza plans; catastrophic incident plans or annexes; or MOUs/MOAs, informal agreements with lead agencies, or comparable documents.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP10.2 *Plans for Crisis Standards of Care (CSC).*	CSC plans address health care operations when a pandemic or other large-scale incident overwhelms routine health care system operations. **Function 2:** Support activation of medical surge. **Task 2:** Activate alternate care facilities. Assist health care organizations and health care coalitions with monitoring and activating alternate care facilities, as requested. **P13:** Legal and regulatory mechanisms to support surge activities at the jurisdictional level and identification and engagement of the health care workforce to execute the mechanisms.	CSC plans must be initiated when there is a substantial change or a catastrophic event that overwhelms routine health care operations.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP10.2 Because of the unpredictability and sudden onset of a catastrophic incident, it is much more difficult to develop specific CSC plans, but plans must be in place for when the severity of incident impacts the health care system. Evidence for CSC must clearly document triggers for assessment of the health care infrastructure. Plans must also describe how triggers lead to alerting stakeholders about enacting CSC and moving from conventional to emergency care; likewise, CSC plans must address when jurisdictions can retract CSC and resume routine health care system operations.	Acceptable Evidence • CSC CONOPS plans. • CSC plans.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP10.3a-f *Procedures in place for information exchange between public health and health care sectors regarding* *a. Staffing status,* *b. Alternative care sites,* *c. Bed status,* *d. Critical service/infrastructure status,* *e. Essential medical supplies and services, and* *f. Patient census.*	Address the health department's plans for coordination, collaboration, and integration of information with health care sectors to ensure situational awareness. **Function 2:** Support activation of medical surge. **P3: (Priority)** Jurisdictional procedures in place to identify critical information sharing requirements (situational awareness information) for partners and stakeholders. **Function 3:** Support jurisdictional medical surge operations. **Task 1:** Identify public health guidance and recommendations. **Task 2:** Coordinate with partners to provide required resources. **P1: (Priority)** Procedures in place to collect, communicate, and share situational awareness information including number and types of patients seen by location, to partners and stakeholders, through jurisdictional emergency management procedures.	An effective plan for sharing essential elements of information (EEIs) increases situational awareness between health care partners/agencies and the public health systems. Plans that address timely coordination and exchange of EEIs between public health and health care stakeholders during a public health emergency event will facilitate situational awareness to support medical surge.

Reviewer Guidance	Required Documentation	Submission Frequency
Evidence must document a process for a centralized source to exchange incident-specific, sensitive information, such as a health care information system (HIS), among health care and relevant stakeholders via a secured network. **CAP10.3a** Evidence must document plans for exchanging EEI throughout the duration of a response for staffing including status about availability and shortages. See also CAP10.1b, regarding bidirectional feedback. **CAP10.3b** Evidence must document plans for exchanging EEI about alternate care sites operational status, capacity, medical needs, and AFN services. See also CAP7.3. **CAP10.3c** Evidence must document plans for exchanging EEI throughout the duration of the response for hospital and skilled nursing facilities (SNF) bed capacity, status, and availability. **CAP10.3d** Evidence must document plans for exchanging EEI throughout the duration of the response for critical service and infrastructure status and capacity in health care systems; plans must address how information about general operations including utility services, food, and water supplies will be managed and exchanged. **CAP10.3e** Evidence must document plans for exchanging EEI throughout the duration of the response for essential medical supplies including supply chain integrity, security and movement, and services. **CAP10.3f** Evidence must document plans for exchanging EEI throughout the duration of the response for patient census including key demographics, tracking, transfers, and evacuations.	Acceptable Evidence • ESF-8 hazards plans or annexes; operations response plans; COOP plans or annexes; pandemic influenza plans; catastrophic incident plans or annexes; or MOUs/MOAs, informal agreements with lead agencies, or comparable documents.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP10.4 *Plans describe family reunification for displaced persons.*	Address the role of public health to coordinate or support family reunification. **Function 3:** Support jurisdictional medical surge operations. **Task 1:** Maintain communications and continuity of services. **Task 2:** Coordinate with partners to provide required resources. **Task 3:** Track patients impacted by the incident. Coordinate with jurisdictional partners and stakeholders to facilitate patient tracking during the incident response and recovery. **P3: (Priority)** Procedures in place to support or implement family reunification.	After a catastrophic event, most people immediately check on the well-being of family and friends. Managing the movement of displace persons is an essential function for emergency management. Public health can amplify the need to assure displace persons requiring medical attention are appropriately monitored and families properly informed about the movement and location of their loved ones.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP10.4 Evidence must document the lead agency, public health or not, and substantiate public health preparedness program's understanding of the roles and responsibilities for family reunification. Evidence must also describe the process for tracking, managing, and informing families about displaced persons throughout the duration of the incident.	Acceptable Evidence Evidence is required for all sub-elements, regardless of public health's role, to assure public health preparedness programs understand how the jurisdiction structure supports these elements. • ESF-8 hazard plans or annexes; family reunification plans or annexes; emergency response plans; COOP plans or annexes; pandemic influenza plans; catastrophic incident plans or annexes; or MOUs/MOAs, informal agreements with lead agencies, or comparable documents. • Established electronic databases. • Pre-identified family reunification center or equivalent facilities; prepared emergency information for rapid dissemination to families, or readiness and emergency management for schools (REMS) documentation or practice drills.	At a minimum, review annually and update as necessary; validate at least every three years.

Capability 11: Nonpharmaceutical Interventions

Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health

Definition

Nonpharmaceutical interventions (NPI) are actions that people and communities can take to help slow the spread of illness or reduce the adverse impact of public health emergencies. This capability focuses on communities, community partners, and stakeholders recommending and implementing NPIs in response to the needs of an incident, event, or threat. NPIs include isolation and quarantine; restrictions on movement and travel advisories/warnings; social distancing; external decontamination; hygiene; and precautionary protective behaviors.

Element	Purpose	Significance
CAP11.1a-d *Plans for NPI include* *a. Regulatory/legal authorities,* *b. Triggers for activation,* *c. Threshold for deactivation, and* *d. Public education.*	Address process to develop and implement NPIs in the jurisdiction. **Capability 11, Function 1:** Engage partners and identify factors that impact NPIs. **Task 1:** Identify authorities, policies, and other factors that impact NPIs. **P1: (Priority)** Documentation of applicable jurisdictional, legal, and regulatory authorities and policies for recommending and implementing NPIs in incident-specific situations. **P2: (Priority)** Identification and documentation of local conditions or incident characteristics that are relevant to the NPI decision-making process. **Function 2:** Determine NPIs. **Task 1:** Engage SMEs to assess exposure or transmission. **P2: (Priority)** Procedures in place to develop NPI recommendations specific to the incident and based on science, risks, resource availability, and legal authorities. **Function 3:** Implement NPIs. **Task 7:** Inform the public, responder agencies, and other partners or recommendations for NPIs. **P7:** Templates and intervention-specific public education materials that are modifiable at the time of the incident. **Function 4:** Monitor NPIs. **Task 1:** Assess implementation and effectiveness NPIs. **Task 2:** Provide updated information to partners related to the use of NPIs. **P1: (Priority)** Procedures in place, developed in consultation with appropriate public health officials, to monitor the effectiveness of NPIs based on surveillance data and other information.	NPI actions can help slow the spread of illness and are also referred to as community mitigation strategies. An effective NPI strategy must identify authorities, policies, and other community factors that might impact the effectives of an NPI.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP11.1a-d Evidence must document plans for recommending NPIs. Plans must describe the legal or regulatory authority in the jurisdiction to implement NPIs and any potential legal barriers to NPI implementation. Limitations if applicable of the legal authority must be described and specify at which jurisdictional hierarchy it applies, local, county, or state. Evidence must also describe triggers to initiate NPI decisions and who must be involved such as agencies or relevant SMEs. Plans must also document how once implemented NPIs are monitored, modified, communicated, and rescinded. Plans must document how the impacted community will be continuously informed and educated. See also PPS; CAP4.3a-b.	Acceptable Evidence • ESF-8 hazard plans or annexes; emergency response plans; COOP plans or annexes; pandemic influenza plans; catastrophic incident plans annexes; or MOUs/MOAs, informal agreements with jurisdictional partners, or comparable documents.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP11.2 Plans for NPI document partner roles and responsibilities (select lead, support, or no role).	Review plans to assess the health department roles and responsibilities and coordination with jurisdictional partners and stakeholders to implement and, if necessary, enforce the NPI recommendations. **Function 1:** Engage partners and identify factors that impact NPIs. **Task 2:** Determine jurisdictional roles and responsibilities related to NPIs.	Early NPI implementation may help slow the acceleration of cases in the jurisdiction. Roles and responsibilities for health department staff should be delineated to support necessary implementation actions.

Reviewer Guidance	Required Documentation	Submission frequency
CAP11.2 Evidence must document the lead agency, public health or others, and substantiate public health understanding of the roles and responsibilities of partners when making recommendations about community mitigation interventions. Plans must also document how partners will be leveraged in the NPI notification and education process.	Acceptable Evidence • ESF-8 hazard plans or annexes; emergency response plans; COOP plans or annexes; pandemic influenza plan; catastrophic incident plan/annex; or MOUs/MOAs, informal agreements with jurisdictional partners, or comparable documents.	At a minimum, review annually and update as necessary; validate at least every three years.

Capability 12: Public Health Laboratory Testing

Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health

Definition

Public health laboratory testing is the ability to implement and perform methods to detect, characterize, and confirm public health threats. It also includes the ability to report timely data, provide investigative support, and use partnerships to address actual or potential exposure to threat agents in multiple matrices, including clinical specimens and food, water, and other environmental samples. This capability supports passive and active surveillance when preparing for, responding to, and recovering from public health threats and emergencies.

PHEP funding supports Laboratory Response Network (LRN) for Biological Threats Preparedness (LRN-B) and LRN for Chemical Threats Preparedness (LRN-C) laboratories within the national network. **CDC will evaluate PHEP jurisdictions with laboratory responsibilities on select requirements in Capability 12: Public Health Laboratory Testing. Those jurisdictions include all 50 states, Los Angeles County, New York City, and Washington, D.C.**

To the extent possible, planning data includes the latest relevant survey data received from the Association of Public Health Laboratories (APHL) annual assessment of state and large local public health laboratory preparedness and APHL's public health laboratory database for equipment and test result details. Proficiency testing data includes the most recent PHEP-funded proficiency data received from LRN-B and LRN-C. Jurisdictions without preloaded data, must address the measures and upload evidence that demonstrates planning and operational proficiency; information will not display for jurisdictions that did not submit APHL survey responses. **Local reviews are designated at the discretion of the state. Local ORR measures for laboratory testing capability align with PPHR review for laboratory capability. See JSS requirements.**

Element	Purpose	Significance
CAP12.1 Public health laboratory has implemented a laboratory information management system (LIMS) to receive and report laboratory information electronically (e.g., electronic test orders and reports with hospitals and clinical laboratories, surveillance data from public health laboratory to epidemiologist; answer choices: yes, bidirectional capability to receive and report; receive only; report only; no, electronic messaging capability.) **CAP12.1L** (local planning jurisdictions) The plan contains evidence of the database and protocol for management and flow of laboratory data and sample testing information.	Review laboratory function for routine, emerging, and novel threat detection and data sharing procedures. **Capability 12, Function 1:** Conduct laboratory testing and report results. **Task 2:** Conduct specimen sample testing. **E/T2: (Priority)** Laboratory equipment and instruments serviced, inspected, and certified. **Task 4:** Maintain plans for surge and continuity of operations. **P9: (Priority)** Procedures in place for a laboratory COOP plan to ensure the ability to conduct ongoing testing on routine and emerging public health threats. **E/T5: (Priority)** LIMS is routinely updated and maintained to send testing data to CDC according to CDC-defined standards.	Sharing information with appropriate partners when a novel or emerging threat is identified can expedite any necessary action. A LIMS helps establish standards for rapidly exchanging information in a secure manner. Integrating software, which LRN laboratories use to store internal records, with an automated messaging service that can send critical results directly to CDC and other relevant partners increases access to timely, relevant information.

Element	Purpose	Significance
	Function 2: Enhance laboratory communications and coordination. **Task 1:** Ensure effective information exchange. **Task 2:** Coordinate with preparedness partners to support public health investigations. **Task 3:** Provide investigative consultation and technical assistance. **P1: (Priority)** Procedures in place to facilitate cooperation, coordination, and information sharing with and among stakeholders. **P2: (Priority)** Procedures or guidelines in place to coordinate with relevant stakeholders in specific incidents.	

Reviewer Guidance	Required Documentation	Submission Frequency
CAP12.1 Review information for accuracy and completeness. Supplemental evidence is only required for jurisdictions that did not complete the APHL survey data. Review data entry and supporting evidence, if required. If LIMS does not support bidirectional communication, consider this an area to address in action plans. **CAP12.1L (local planning jurisdictions)** Evidence must describe how rapid exchange of secure information is addressed. If the evidence does not support bidirectional communication, consider this an area to address in action plans.	APHL all-hazards laboratory preparedness survey results are imported for review; no additional data entry or supplemental evidence is required if data fields are filled in. If data is not shown, complete the relevant questions and submit supporting evidence. **Local planning jurisdictions:** Provide evidence for the secure exchange of information between the local health department and the laboratory for specimen identification and shipment. Acceptable Evidence • Applicable certifications, licensures, or confidentiality protocols. • Dedicated IT support personnel or contractual agreements with vendors. • ESF-8 hazard plans or annexes; laboratory plans or annexes; emergency response plans; COOP plans or annexes; pandemic influenza plans; catastrophic incident plans or annexes; or MOUs/MOAs, informal agreements with lead agencies, or comparable documents. • Laboratory protocols, system procedures, or timelines. • SOPs, written agreements, or communication plans.	**States:** Data is uploaded from APHL survey annually. Verify data with laboratorians, if necessary. **Local jurisdictions:** At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP12.2a-c Staff has received training on the following topics. *a. BSL-2 standard and special practices (fundamentals of biological materials safety practices, excluding bloodborne pathogen training; yes, no, additional training is needed).* *b. Certification in packaging and shipping of Division 6.2 infectious substances (including Category A; yes, no, additional training is needed).* *c. BSL-3 standard and special practices (yes, no, additional training is needed).* **CAP12.2aL-cL (local planning jurisdictions)** *aL. The plan describes current packaging and shipping regulations on transporting infectious and potentially hazardous substances to labs that can test for biological/chemical/radiological agents* *bL. The plan describes the process for transporting specimens/samples to a confirmatory reference lab at any time* *cL. The plan describes the process of contacting the proper laboratory with information on what specimens to expect and, if applicable, special directions.*	Review protocols for handling, packaging, shipping, transport, and other aspects of chain of custody. **Function 3:** Support training and outreach. **Task 1:** Facilitate access to training for handling, packaging, and shipping samples. **Task 2:** Maintain chain of custody procedures. **P1: (Priority)** Procedures in place for sample collection, triage, labeling, packaging, shipping, transport, handling, storage, and disposal. Sample collection procedures should include 24/7 contact information and submission criteria in accordance with applicable requirements, such as requirements from the International Air Transport Association (IATA), U.S Department of Transportation (DOT), and Federal Select Agent Program. **S/T3:** Biological, chemical threat laboratory personnel trained annually on chain of custody procedures. Documentation should include training date(s) and manner of delivery, such as formal training or "train the trainer."	Shipping and handling samples in accordance with IATI, and DOT standards is critical for rapid, safe transport and receipt during public health emergencies.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP12.2a-c Review information for accuracy and completeness. Supplemental evidence is only required for jurisdictions that did not complete the APHL survey data. Evidence must describe adequate training for specimen packaging and shipping. If training is lacking, consider this an area to address in action plans. **CAP12.2aL-bL (local planning jurisdictions)** Evidence must describe adequate plans for specimen packaging shipping, and transport. Transportation resources must be accessible 24/7. Consider this an area to address in action plans if plans lack detail. **CAP12.cL (local planning jurisdictions)** Evidence must describe how rapid exchange of secure information is addressed. If the evidence does not support bidirectional communication, consider this an area to address in action plans.	APHL all-hazards laboratory preparedness survey results are imported for review; no additional data entry or supplemental evidence is required if data fields are filled in. If data is not shown, complete the relevant questions and submit supporting evidence. **Local planning jurisdictions** Provide evidence of packaging and shipping capability. Use of another agency, area laboratory, or shipping agent is acceptable for local jurisdictions. For CAP12.2bL, evidence must indicate that packaging and shipping capability is available 24/7. Acceptable Evidence • Applicable certifications, licensures, or confidentiality protocols. • Chain of custody plans. • ESF-8 hazard plans or annexes; laboratory plans or annexes; operations response plans; COOP plans or annex; pandemic influenza plans; catastrophic incident plans or annexes; or MOUs/MOAs, informal agreements with lead agencies, or comparable documents. • Protocols in place for packaging and shipping consistent with DOT and/or IATA Division 6.2 guidance.* • SOPs, written agreements, or communication plans. • Staff training on protocols by participant must comply with current DOT and IATA regulations and guidelines • Valid Division 6.2 infectious substance shipping certifications for staff responsible for packaging and shipping for the laboratory. Under the Code of Federal Regulations (CFR), Division 6.2 is infectious substance, which means a material known or reasonably expected to contain a pathogen.	**States:** Data is uploaded from APHL survey annually. Verify data with laboratorians, if necessary. **Local jurisdictions:** At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP12.3 Laboratory has a biosafety officer (yes, full time; yes, part time; no, explain why there is no staff).	Review protocols for handling, packaging, shipping, transport, and other aspects of chain of custody. **Function 3:** Support training and outreach. **Resource Element P4:** A designated biological safety officer or official (BSO) for technical support and guidance regarding internal laboratory activities and technical assistance to strengthen biosafety in sentinel clinical laboratories. **Resource Element S/T5:** Laboratory adherence to appropriate regulatory requirements. **Task 1:** Facilitate access to training for handling, packaging, and shipping samples. **Task 2:** Maintain chain of custody procedures.	

Reviewer Guidance	Required Documentation	Submission Frequency
CAP12.3 Review information for accuracy and completeness. Supplemental evidence is only required for jurisdictions that did not complete the APHL survey data. Evidence must document the laboratory has a biosafety officer. If there are concerns with providing a BSO, consider this an area to address in action plans.	APHL all-hazards laboratory preparedness survey results are imported for review; no additional data entry or supplemental evidence is required if data fields are filled in. If data is not shown, complete the relevant questions and submit supporting evidence. Acceptable Evidence • Applicable certifications, licensures, or confidentiality protocols. • Chain of custody plans. • ESF-8 hazard plans or annexes; laboratory plans or annexes; emergency response plans; COOP plans or annexes; pandemic influenza plans; catastrophic incident plans or annexes; or MOUs/MOAs, informal agreements with lead agencies, or comparable documents. • Job descriptions or job action sheets. • Protocols in place for packaging and shipping consistent with DOT and/or IATA guidance. • SOPs, written agreements, or communication plans. • Staff training on protocols by participant must comply with current DOT and IATA regulations and guidelines. • Valid Division 6.2 infectious substance shipping certifications for staff responsible for packaging and shipping for the laboratory. Under CFR, Division 6.2 is an infectious substance, which means a material known or reasonably expected to contain a pathogen.	**States:** Data is uploaded from APHL survey annually. Verify data with laboratorians, if necessary. **Local jurisdictions**: At a minimum, review annually and update as necessary; validate at least every three years.

Capability 13: Public Health Surveillance and Epidemiological Investigation

Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health

Definition

Public health surveillance and epidemiological investigation is the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes. It also includes the ability to expand these systems and processes in response to incidents of public health significance

NOTE. Jurisdictions with current PHAB accreditation receive full credit for Capability 13, Public Health Surveillance and Epidemiological Investigation ORR elements.

Element	Purpose	Significance
CAP13.1a-d *Public health surveillance and epidemiological plans address* *a. Legal authority,* *b. Protocols,* *c. Analyses and reports, and* *d. Emergency coverag.e*	Review the process for collecting and managing data for public health surveillance. **Capability 13, Function 1:** Conduct or support public health surveillance. **P1: (Priority)** Legal and procedural frameworks for jurisdiction personnel involved in surveillance and epidemiology to support mandated and voluntary information exchange with partners and stakeholders **P2:** Procedures in place to gather and analyze data on a broad range of health indicators. **P4: (Priority)** Procedures in place for the jurisdictional public health agency to access, collect, analyze, interpret, and respond to reports of potential public health threats or incidents. **S/T1:** Public health personnel who participate in data collection, analysis, and reporting to support surveillance investigations are trained. **Task 2:** Conduct or support routine and incident-specific surveillance. **Function 2:** Conduct public health and epidemiological investigations. **P2:** Procedures in place to support jurisdictional methods for conducting investigations of public health, environmental, and occupational threats, incidents, and hazards.	Public health surveillance acts as an early warning system to detect potential public health emergencies. Continuous and systematic collection, analysis, and interpretation of health-related data is the cornerstone for public health practice.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP13.1a-d Evidence must document the public health department's authority to conduct surveillance and epidemiological investigations. Routine public health surveillance must be established to monitor nationally reportable infectious diseases, syndromic surveillance, and noninfectious diseases. Evidence must demonstrate a process for routine analysis of surveillance data to rapidly identify threats or incidents of public health significance. Documentation must describe methods to routinely assess deviations from expected disease trends and evidence of protocols to initiate epidemiological investigations when thresholds are exceeded. Evidence must also describe procedures for conducting investigations of suspected or identified outbreaks related to public health disease surveillance, threats, or exposures. Plans must address how staff is scaled for incident-monitoring and potential epidemiological investigations, including coverage outside of routine business hours.	Acceptable Evidence • ESF-8 hazard plans or annexes; mass fatality plans or annexes; emergency response plans; COOP plans or annexes; pandemic influenza plans; catastrophic incident plans or annexes; or MOUs/MOAs, informal agreements with lead agencies or comparable documents. • Process(es) and protocol(s) that include how data are collected such as emails, web reports, and electronic data transfer. • SOPs, written agreements, or communication plans. • Surveillance reports.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP13.2 Surveillance partners are routinely verified.	Assess partnerships for public health surveillance and reportable diseases reporting. **Function 1:** Conduct or support public health surveillance. **P5: (Priority)** Regularly updated and verified list(s) of identified stakeholders who will share, receive, and distribute surveillance reports. **Task 1:** Engage stakeholders to support public health surveillance and investigation. Coordinate activities with jurisdictional laboratories, partners, and stakeholders who can provide public health-related surveillance data to support routine and emergency responses requiring surveillance and epidemiological investigation.	Surveillance systems can be used to signal a public health alert based on underlying protocols. However, people are necessary to create, maintain, and react to indications that require further epidemiological investigation. Maintaining accurate lists of stakeholders who both support surveillance efforts and contribute to epidemiological investigations encourages ongoing engagement.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP13.2 Evidence must document a process for maintaining key surveillance partners at federal, state, and local levels such as epidemiologists, environmentalists, laboratorians, and clinicians. Evidence must also describe how stakeholders are routinely engaged for surveillance and epidemiological investigations when indicated.	Acceptable Evidence • Contact list of active surveillance partners who contribute data or receive reports. • ESF-8 hazard plans or annexes; mass fatality plans or annexes; emergency response plans; COOP plans or annexes; pandemic influenza plans; catastrophic incident plans or annexes; or MOUs/MOAs, informal agreements, or comparable documents that show evidence of established partnerships for disease investigation. • SOPs and written agreements to authorize joint investigations and information exchange.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP13.3a-b *Procedures for confidential, sensitive, and restricted data including* *a. Secure storage and* *b. Secure sharing.*	Review process for data confidentiality. **Function 2:** Conduct public health and epidemiological investigations. **Task 3:** Share public health and epidemiological investigation findings. **P3:** Procedures in place to establish partnerships, conduct investigations, and share information with other governmental agencies, partners, and organizations. **P4:** Written agreements, such as contracts or MOUs, to authorize joint investigations and information exchange. **E/T2:** Information systems to aid in the development of public health investigation reports using available and relevant information.	The Security Rule is a federal law that requires appropriate administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP13.3a-b Evidence must satisfy standards for data security compliance and prevent unauthorized disclosure of confidential, sensitive, or restricted information. Evidence must describe relevant data regulations and requirements for secure storage and exchange including relevant format, structure, and interoperability requirements.	Acceptable Evidence • Data use and release parameters or data storage plans. • ESF-8 hazard plans or annexes; mass fatality plans or a annexes; emergency response plans; COOP plans or annexes; pandemic influenza plans; catastrophic incident plans or annexes; or MOUs/MOAs, informal agreements with lead agencies, or comparable documents. • SOPs or written agreements to authorize joint investigations and information exchange.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP13.4 *Plans to initiate and track mitigation actions.*	Review procedures for mitigation to reduce morbidity from outbreaks. **Function 3:** Recommend, monitor, and analyze mitigation actions. **Task 1:** Identify public health guidance and recommendations. **Task 3:** Monitor and assess public health interventions. **P1: (Priority)** Procedures in place, developed in consultation with appropriate public health officials to initiate and sustain surveillance, exposure containment, control, and mitigation actions.	Public health departments must readily act to initiate and sustain surveillance actions to mitigate hazards and outbreaks that have negative consequence for the community.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP13.4 Evidence for mitigation decisions must describe how jurisdictions use surveillance and epidemiological investigations are used to track mitigation actions, monitor performance, and revise mitigation strategies to optimize containment or mitigate morbidity and mortality. Evidence must also specify any legal authorities or statutory regulations for mitigation requiring contact tracing, quarantine, and isolation. See also CAP11.1a-d and CAP13.1a.	Acceptable Evidence • AARs from prior incidents. • Documents outlining legal authorities for mitigation actions such as school closure, quarantine, isolation, allocation of MCMs, or regulation of environmental exposures. • ESF-8 hazard plans or annexes; mass fatality plans or annexes; emergency response plans; COOP plans or annexes; pandemic influenza plans; catastrophic incident plans or annexes; or MOUs/MOAs, informal agreements with lead agencies, or comparable documents. • Improvement plans.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP13.5a-b *Quality improvement for* *a. Routine public health surveillance systems and* *b. Public health investigations.*	Assess quality improvement plans for maintaining surveillance systems. **Function 4:** Improve public health surveillance and epidemiological investigation systems. **Task 1:** Evaluate effectiveness of public health surveillance and epidemiological investigation processes and systems. **Task 2:** Identify and prioritize corrective actions. **Task 3:** Establish an after-action process, share (AARs/IPs), and implement and monitor corrective actions. **P1: (Priority)** Procedures in place to assess jurisdictional response effectiveness. **P2: (Priority)** Procedures in place to communicate AAR/IP findings to data submitters and other key partners and stakeholders.	Quality improvement (QI) is a systematic approach to analyze performance and inform decisions that improve outcomes. Surveillance and epidemiological QI efforts should lead to advances in surveillance system performance and epidemiological knowledge.

Reviewer Guidance	Required Documentation	Submission Frequency
The scope of public health investigations covers any epidemiological, environmental, chemical, radiological, or other investigation regarding a potential public health emergency. **CAP13.5a** Evidence must describe improvements to protocols, systems, training, equipment, or adoption of new technology, standards, or best practices. **CAP13.5b** Evidence must describe what triggers a QI review following epidemiological investigations for infectious disease outbreaks, public health hazards, natural disasters, and other threats. See WDT3.e.	Acceptable Evidence • AARs or corrective action plans. • Publications based on responses that contribute to preparedness and response science. • Reports or publications that critique the effectiveness of incident characterization. • Updated epidemiology and surveillance plans, or annexes.	At a minimum, review annually and update as necessary; validate at least every three years.

Capability 14: Responder Safety and Health

Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health

Definition

Responder safety and health is the ability to protect public health and other emergency responders during pre-deployment, deployment, and post-deployment.

Element	Purpose	Significance
CAP14.1a-c Public health responder safety and health plans include *a. Safety officer or equivalent roles and responsibilities,* *b. Potential hazards or risks responders might encounter during an incident, and* *c. Health and safety assessment for responders.*	Review health department's roles, responsibilities, and safety plans for agency responders for various types of hazards and risks. **Capability 14, Function 1:** Identify responder safety and health risks. **Task 1:** Identify and prioritize safety and health risks. **Task 2:** Identify, prioritize, and recommend protection and control measures, medical services, and mental/behavioral health support services for responders. **Task 3:** Develop or refine incident safety plan. **P2: (Priority)** Defined public health agency roles and responsibilities for responder safety and health, such as conducting public health assessments, potable water inspections, field interviews, and points of dispensing staffing, related to identified jurisdictional risks established in conjunction with partner agencies. **S/T1**: Public health personnel who fill the role of incident safety officer trained to perform core functions, such as coordination, communications, resource dispatch, and information collection, analysis, and dissemination.	A safe and healthy workforce is necessary for an effective, comprehensive response and recovery. Responder safety and health focuses on the ability to protect public health emergency response staff throughout the response cycle (pre-deployment, deployment and post-deployment).

Reviewer Guidance	Required Documentation	Submission Frequency
CAP14.1a Safety officer is part of the command staff in the ICS. Evidence must document that the safety officer's roles and responsibilities include oversight for pre-deployment health assessments that evaluate a responder's ability to safely perform the expected functions. Plans must also address how the safety officer will address potential hazards that responders may encounter, given the nature of an incident. See also CAP3.3l. **CAP14.1b** Evidence must document how potential hazards and risks will be monitored throughout the duration of the response. Plans must address both potential acute and chronic health risks to responders given the nature of the most likely jurisdictional hazards, this includes cross-checking the process against the JRA. **CAP14.1c** Evidence must document the plans for assessing and developing recommendations for responders' health and safety. Plans must describe how SMEs will be used to inform or provide consultation in situations where technical expertise is required. Local planning jurisdictions might rely on state plans for relevant detail regarding responder safety and health, which is acceptable if the local jurisdiction demonstrates the state plans are integrated with local functions.	Acceptable Evidence • Contact list of SMEs (CAP14.1c). • ESF-8 hazard plans or annexes; mass fatality plans or annexes; emergency response plans; volunteer health and safety plans or annexes; responder safety and health plans; catastrophic incident plans or annexes; or MOUs/MOAs, informal agreements with lead agencies, or comparable documents. • Job descriptions, job action sheets, or other documents that identify roles and responsibilities of a safety officer as a key member of ICS or comparable emergency operations structure. • Other documents such as recovery plans that outline requirements and duties; roles and responsibilities; and required qualifications or skillset for the safety officer.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP14.2a-b Plans for providing personal protective equipment (PPE) include *a. Appropriate scalability given the incident and* *b. Training in proper use.*	Review plans to mitigate risks using PPE for responders during an emergency. **Function 1:** Identify responder safety and health risks. **P5: (Priority)** PPE recommendations for responders, including public health responders, developed in conjunction with partner agencies. **S/T2:** Personnel trained to use various types of PPE and decontamination procedures when responding to chemical, biological, and radiological incidents. **S/T3:** Personnel trained on jurisdictional systems for population monitoring to identify risks and recommendations for PPE training is recommended for various responder types.	PPE is a primary protection measure for responders. Depending on the type of public health emergency, it is necessary to protect all responders from physical, chemical, and biological hazards. Proper training on the use and disposal of PPE helps protect the safety and health of responders.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP14.2a Evidence must document procedures for securing PPE for responders given the nature of the event. **CAP 14.2b** Evidence must document plans for providing training for proper use, care, and disposal of PPE.	Acceptable Evidence • ESF-8 hazard plans or annexes; mass fatality plans or annexes; emergency response plans; volunteer health and safety plans or annexes; responder safety and health plans; catastrophic incident plans or annexes; or MOUs/MOAs, informal agreements with lead agencies, or comparable documents. • Health and safety plan. • Hazard exposure risk assessment. • Site safety and control plan (ICS 208 Hazardous Materials [HM]). • Training materials used for PPE training.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP14.3a-c Plans for pre-deployment assessment of public health responders include *a. Physical health screenings,* *b. Mental/behavioral health screenings, and* *c. Countermeasure considerations.*	Assess pre-deployment screening and verification of responder health status, including physical and mental health. **Function 1:** Identify responder safety and health risks. **Task 4:** Support responder eligibility confirmation. **P4:** Procedures in place to determine responder eligibility for deployment based on medical readiness, physical and mental/behavioral health screenings, background checks, and verification of credentials and certifications. **Function 2:** Identify and support risk-specific responder safety and health training. **Task 1:** Determine responder safety and health training needs. **P1: (Priority)** Procedures in place to ensure the completion, verification, and documentation of responder safety and health training prior to and during an incident. **Function 3:** Monitor responder safety and health during and after incident response. **Task 6:** Provide mental/behavioral and medical support services. **P4: (Priority)** Procedures in place for monitoring, exposure assessment, and sampling activities to assess levels of environmental exposure and effects on individual responders and procedures in place for surveillance activities.	Responders with specialized training to support emergencies are generally the first on the scene and last to leave. Addressing the mental, behavioral, and physical health and welfare of responders by assessing overall well-being prior to deployment is key to maintaining a ready responder force. Providing responders with appropriate countermeasures relative to the incident is equally important to support a successful responder cadre.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP14.3a-b Evidence must document the criteria requiring pre-deployment assessments given the nature of the incident. Plans for physical and behavioral health screening must describe minimal standards for deployment and be conducted by staff with appropriate medical and behavioral education, licenses, and clearances. **CAP14.3c** Evidence must document plans to address countermeasure considerations relative to the response for responders. At minimum, plans must address how necessary prophylaxis and immunizations will be delivered for potential response roles. Pandemic influenza plans must be reviewed and include a process for prioritization of critical workforce groups, in particular responders under the authority of public health, given a limited supply scenario in accordance with CDC's Allocating and Targeting Pandemic Influenza Vaccine Guidance. State plans must also document who will provide countermeasures to state assets, regardless of the entity responsible for administering.	Acceptable Evidence Pandemic influenza plans (required for CAP14.3c). • ESF-8 hazard plans or annexes; mass fatality plans or annexes; emergency response plans; volunteer health and safety plans annexes; responder safety and health plans; catastrophic incident plans or annexes; or MOUs/MOAs, informal agreements with lead agencies, or comparable documents, • Safety and health inspection checklist or equivalent.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP14.4a-c Scalable plans for public health responders (during and after response) include *a. Just-in-time training,* *b. Injury and morbidity surveillance, and* *c. Post deployment monitoring.*	Assess the safety and health of responders during and after an incident including services to support potential training, medical, and mental/behavioral health needs. **Function 2:** Identify and support risk-specific responder safety and health training. **Task 2:** Support safety and health training initiatives. **Function 3:** Monitor responder safety and health during and after incident response. **Tasks 1-3:** Conduct responder safety and health monitoring and surveillance; document additional incident-specific safety and health risks; and update incident safety plan.	Having flexible and scalable plans to accurately address just-in-time training will be needed to effectively maintain the safety and health of responders during an event. Monitoring individual responders for potential adverse effects allows for proper medical support as necessary.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP14.4a Even with proactive training plans for responders, often "just-in-time" training is necessary to address nuances specific to the incident. Plans must document how "just-in-time" training will be developed and implemented to address immediate needs and any changes to previously trained responder roles and duties. **CAP14.4b** Evidence must address considerations for appropriate level of safety monitoring and health surveillance for responders based on identified risks, responder roles, and SME recommendations. **CAP14.4c** Evidence must describe how responders will be monitored after demobilization and out-processing. Plans must specify how monitoring for any immediate or long-term adverse physical and mental/behavioral health changes attributable to the response will be maintained following demobilization. See also CAP15.1h.	Acceptable Evidence • Emergency Responder Health Monitoring and Surveillance (ERHMS) system in place, • ESF-8 hazard plans or annexes; mass fatality plans or annexes; emergency response plans; volunteer health and safety plans or annexes; responder safety and health plans; catastrophic incident plans or annexes; recovery plans; or MOUs/MOAs, informal agreements with lead agencies, or comparable documents, • Job aids, • Just-in-time training curriculum and materials, • SME guidance, • Training logs, • Written agreements for provision of services,	At a minimum, review annually and update as necessary; validate at least every three years.

Capability 15: Volunteer Management

Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health

Definition

Volunteer management is the ability to coordinate with emergency management and partner agencies to identify, recruit, register, verify, train, and engage volunteers and surge staff to support the jurisdictional public health agency's preparedness, response, and recovery activities during pre-deployment, deployment, and post deployment.

Element	Purpose	Significance
CAP15.1a-i Volunteer management plans include: *a. Recruitment strategies,* *b. Screening and credential verification,* *c. Activation process,* *d. Role criteria and assignment process,* *e. Retention strategies,* *f. Training strategies,* *g. Safety and health monitoring and surveillance,* *h. Out-processing, and* *i. Post-deployment resources.*	Review volunteer management plans in the context of response stages. **Capability 15, Function 1:** Recruit, coordinate, and train volunteers. **Task 2:** Recruit volunteers. **Task 3:** Verify volunteer credentials. **Task 4:** Support volunteer emergency response training. **P1: (Priority)** Volunteers and other resources identified as necessary to respond to public health incidents or events based on jurisdictional risks. **P2: (Priority)** Written agreements, such as contracts or MOUs, established with jurisdictional or regional volunteer sources to address potential public health responses. **P3:** Verification of professional volunteer diplomas, licenses, certifications, credentials, and registrations in accordance with federal and state laws using the state's ESAR-VHP or other programs. **P4:** Deployment eligibility for pre-identified volunteer responders based on medical, physical, and mental/behavioral health screenings and background checks. **S/T1:** Documentation of completed training(s), as required by the jurisdiction, to prepare volunteers for their assigned responsibilities. **S/T2:** Personnel trained in volunteer management. **S/T3:** Prospective volunteers trained in jurisdictional incident management or NIMS trainings.	During large-scale responses or extended public health emergencies, volunteers may be used to augment responder support. Proactive planning, networking, and tracking are necessary components of good volunteer management. An effective volunteer management plan should address potential bottlenecks, which may inhibit timely deployment and efficient use of volunteers during a response.

Element	Purpose	Significance
	Function 2: Notify, organize, assemble, and deploy volunteers. **Task 3:** Notify registered volunteers of incident-specific assignment details. **Task 4:** Request additional volunteers as needed. **P1:** Procedures in place to coordinate with partners, inter- and intra-jurisdictional agencies, and other relevant organizations, contact registered volunteers, identify volunteers willing and able to respond; identify supporting resources needed for volunteers and share incident-specific assignment details.	
	Function 3: Conduct or support volunteer safety and health monitoring and surveillance. **Task 2:** Conduct volunteer safety and health monitoring and surveillance. **P3: (Priority)** Surveillance activities to assess trends in actions and practices that contribute to incident-related physical illness or injury and mental/behavioral trauma. **P4:** Procedures in place to communicate the results of volunteer safety and health monitoring and surveillance to responders, the public, and the media (as applicable). **E/T1:** Surveillance and monitoring systems or databases to track volunteer health and safety. **Function 4:** Demobilize volunteers. **Task 1:** Manage volunteer demobilization and out-processing. **Task 2:** Provide post-incident support to volunteers. **Task 3:** Conduct after-action reviews and develop AARs/IPs. **P1: (Priority)** Procedures in place to ensure proper demobilization of volunteers after a response. **P2:** Procedures in place to provide long-term support for volunteers and conduct periodic assessments of volunteer responder safety and health measures. **E/T1:** Registry or database created in coordination with emergency management entities and used to document volunteer responders exposed to hazards or injured during an incident or response. **E/T2:** Equipment and software to collect, analyze, and report volunteer responder safety and health data during and after an incident or response.	

Reviewer Guidance	Required Documentation	Submission Frequency
CAP15.1a-b Evidence must document the process to identify potential types and number of volunteers, including any surge needs, given the nature of incidents likely in the jurisdiction based on the current JRA. The process for requests must adhere to the relevant jurisdictional hierarchy and document coordination with existing volunteer programs and partner organizations about pre-incident recruitment strategies. Evidence must address the criteria for volunteer eligibility screening including medical, physical, and emotional health assessment. Verification of professional volunteer diplomas, licenses, certifications, credentials, and registrations in accordance with federal and state laws must be documented to ensure issues of liability and scope of practice are addressed. Evidence of recruitment and screening in collaboration with ESAR-VHP, MRC, NVOAD, American Red Cross, Radiation Response Volunteer Corps (RRVC), community emergency response teams (CERTs), and other jurisdictional nongovernmental or community service organizations is encouraged. Different jurisdictions may not recognize "volunteers" in a response. This definition is meant to provide broad interpretation of how volunteers are identified. In jurisdictions where volunteers are not defined or used because of legal or human resource restrictions, "responder" may be considered an equivalent term. **CAP15.1c** Evidence must document that plans for activating volunteers include indicators, alerts, and notification requirements necessary to initiate volunteer use. See also CAP3.2b-c. Triggers to initiate specific volunteer groups and related notification procedures must also be documented and address how rosters are managed to assure alerts are received by appropriate volunteers including ESAR-VHP, MRC, and CERTs. See also CAP15.2. **CAP15.1d-e** Evidence must address roles, assignments, and retention strategies for volunteers. Plans must also describe necessary skills, knowledge, and credentials as applicable, for established volunteer roles and tasks. **CAP15.1f** Even with proactive training plans for volunteers, often "just-in-time" training is necessary to address nuances specific to the incident. Plans must document how "just-in-time" training will be developed and implemented to address immediate needs and any changes to previously trained volunteer roles and duties. See also CAP14.4a. **CAP15.1g** Evidence must address considerations for appropriate level of safety monitoring and health surveillance for volunteers based on identified risks, roles, and subject matter expert recommendations. See also CAP14.1b. **CAP15.1h-i** Evidence must describe how volunteers will be monitored after demobilization and out-processing. Out-processing procedures must include a registry that maintains data for volunteer contact information, position, shifts, and location. See also CAP14.4c. Plans must specify how monitoring for any immediate or long-term adverse physical and mental/behavioral health changes attributable to the response will be maintained following demobilization.	Volunteer management plans are usually addressed in either stand-alone volunteer management plans, MCM plans, or annexes using volunteers for PODs and RSS sites. A specific volunteer management plan might be redundant with elements addressed in MCM plans but can be more comprehensive. <u>Acceptable Evidence</u> • ESF-8 hazard plans or annexes; MCM plans or annexes; emergency response plans; volunteer health and safety plans or annexes; responder safety and health plans; or catastrophic incident plans or annexes; • MOUs/MOAs or equivalent documents in place with partnerships and organizations. • Plans with ESAR-VHP, MRC, and other pre-identified partner organizations such as American Red Cross.	At a minimum, review annually and update as necessary; validate at least every three years.

Element	Purpose	Significance
CAP15.2a-d Communication systems for volunteer notification include *a. Primary system,* *b. Last date primary notification system was updated or tested (whichever is more recent),* *c. Backup system, and* *d. Last date backup notification system was updated or tested (whichever is more recent).*	Assess specific methods and systems used to notify volunteers and response staff. **Function 2:** Notify, organize, assemble, and deploy volunteers. **Task 3:** Notify registered volunteers of incident-specific assignment details. Notify pre-incident registered volunteers who are able and willing to respond and share assignment details using multiple modes of communication. **E/T1:** Communication equipment for public health agency personnel to contact volunteer organizations.	Securing volunteer support is only meaningful when communication about needs are clear. Communication equipment, in conjunction with plans, to contact volunteers and supporting organizations is necessary to effectively notify and leverage volunteers during a response. Multiple communication methods, including a backup notification system, should be in place to assure communication continuity with volunteers.

Reviewer Guidance	Required Documentation	Submission Frequency
CAP15.2a-d Evidence for volunteer notification must include a primary and backup system for communication. Evidence must also document system maintenance and include routine communication tests every six months for both the primary and backup systems to targeted volunteer groups.	Provide evidence that there are plans and procedures to use multiple methods and different types of communication systems to effectively notify volunteers during a response. Acceptable Evidence • Detailed evidence of a notification system(s). • System operation plan with records of routine testing and maintenance (required every six months).	Update rosters and validate every six months.

Section 3: Operations

Section Organization

The ORR is organized into three sections: 1) descriptive and demographic, 2) planning, and 3) operations. Section 3 provides guidance about reporting and evaluating drills, exercises, incidents, and events and is organized as described below.

The grey tables provide information about the specific element, pertinent detail on what is required for data entry, and why it is important. The blue tables describe how the reviewer will evaluate the information and when updates are required (submission frequency). Whether responsible for data entry or review, jurisdictions should read both tables to fully understand the ORR guidelines.

Element	Data Entry Guidance	Significance
Standardized nomenclature is used to label each measure. Elements and sub-element are uniquely labeled using the three-letter acronym of the form. For example, "OPS1.a" refers to operational submission, element 1, sub-element a.	Data entry guidance provides detail and clarifies expectations about what is measured.	The implication of the measure is described.

Reviewer Guidance	Required Documentation	Submission frequency
Reviewer guidance provides detail and clarifies expectations about content components the reviewer must identify to deem the information acceptable as sufficient evidence.	Required documentation provides examples about the type of information recipients can submit as evidence to substantiate responses to elements. The examples of required documentation are not exhaustive. Evidence must include a creation or revision date that is in the acceptable range for a given element's submission frequency (annual, three years, or five years). Draft documents, such as updates to plans or AARs, are acceptable with written acknowledgement by the PHEP director, or proxy, that the evidence is valid and used to support the PHEP program. Draft plans that do not meet the criteria will be adjudicated by the reviewer as **insufficient evidence** in the ORR.	Submission frequency details when ORR data must be input for documentation and validation. **Review** means the data entered should be reexamined for accuracy. **Update** means any data that is no longer accurate should be edited. **Validate** means that supporting evidence must be routinely maintained and documents must have dates within the required range.

Operational Activity

Definition

Effective improvement planning serves as an important tool throughout the integrated preparedness cycle (HSEEP 2020). Actions identified during improvement planning help strengthen a jurisdiction's capability to plan, equip, train and exercise (HSEEP 2020). The IPP documents a progressive exercise approach that is adjusted annually to reflect changes in preparedness priorities given exercises or real-world experiences.

Each operational submission is associated with a PHEP program requirement, and every program requirement must include at least one associated area identified for improvement. For example, the annual staff notification and assembly drill might be associated with an improvement action to upgrade the notification system after discovering key incident management staff did not receive the notification during the drill. Likewise, if an activity meets multiple program requirements, such as an EOC activation and the joint functional exercise with emergency management and HCCs, at least two areas of improvement must be identified, one for the EOC activation and one for the joint exercise.

Element	Data Entry Guidance	Significance
OPS1.a-i *Description of operation* *a. Name of exercise/event/ incident,* *b. Exercise, incident or event start date/time,* *c. Exercise, incident or event end date/time,* *d. Category,* *e. Partners involved,* *f. Capabilities applied,* *g. AAR submission due,* *h. Area(s) identified for improvement, and* *i. EOC activated (y/n).*	Record descriptive information. Training submissions, such as drills and exercises, should align with the WDT, IPPW and multiyear IPP plans. **OPS1.a** Enter a unique activity name. **OPS1.b** Indicate the start date and time. A start time must be documented for drills: 24/7 emergency contact drill-bidirectional, facility setup drill, staff notification and assembly drill, site activation drill, and dispensing throughput drill. Otherwise, if time is not documented, skip. **OPS1.c** Indicate the end date and time. If activity is submitted prior to the conclusion of the incident, skip and revisit when the activity concludes. An end time must be documented for drills. See OPS1.c. Otherwise, if time is not documented, skip. **OPS1.d** Select all options that apply: anthrax, bioterrorism incident other than anthrax, infectious disease outbreak, natural disaster, national security event, pandemic influenza or virus, seasonal influenza, PHEP-funded LRN-B samples testing, LRN-C samples testing using core methods, PHEP-funded LRN-C samples testing using additional methods, PHEP-funded LRN-C SPaSE, PHEP 24/7 bidirectional emergency contact drill, or other, specify. **OPS1.e** Submit the names of partners that participated in the activity. Pertinent partners must be entered for credit for the annual PHEP exercise with vulnerable populations and the joint functional exercise with emergency management and HCC. **OPS1.f** Indicate what capabilities were practiced. Ideally, over the course of the cooperative agreement performance period, all capabilities will be exercised to some degree. **OPS1.g** The AAR deadline is automatically calculated from the end date. This is a reminder only. Date of submission for drills and exercises is based on HSEEP guidelines. Interim reports are acceptable for incidents and events that have prolonged activations or require significant review by jurisdictional leadership, including emergency management partners and executive branch representatives. **OPS1.h** Enter brief statements about areas for improvement based on the corresponding AAR section. These should align with jurisdictional training and integrated preparedness planning. See WDT3.d. Areas for improvement should advance preparedness and strengthen capability, training, and exercise plans as outlined in HSEEP 2020. At least one area of improvement must be included for each program requirement submitted. **OPS1.i** Enter all EOC activations for the jurisdiction. At least one EOC activation submission is required annually. If there is no incident that requires an EOC activation, a site activation drill activating the EOC must be conducted and submitted. See OPS2.a, OPS2.c and SAD1.a-f. For each EOC activation reported, at least one area of improvement must be reported. See OPS1.i.	CDC requires PHEP recipients to meet annual and five-year program requirements. To meet these requirements, recipients must adopt an HSEEP framework in planning and exercising to ensure consistent and interoperable approach to improvement planning. Public health emergencies and incidents do not include exercise objectives but documentation of strengths, areas for improvement, capability performance, and corrective actions are reported and verified in after-action report/ improvement plans (AAR/IPs).

Reviewer Guidance	Required Documentation	Submission Frequency
OPS1.a-d Evidence must document general information for all EOC activations and program requirements completed through drills and exercises. Review evidence for drills, exercises, incidents, and events using HSEEP principles. For tabletop exercises (TTX), functional exercises (FE), and full-scale exercises (FSE), incidents, and events, AARs are due 120 days after the end date. For incidents that have prolonged EOC activations, particularly those occurring in two or more budget periods, interim AARs may be submitted until emergency operations are deactivated. **OPS1.e** Evidence must document identified partners participated in the activity. See PAR1-2 for detailed reviewer guidance. **OPS1.f-g** Review drills and exercises for application of capabilities across activities. Documenting the capabilities included for each activity provides a record of progress. However, practicing distribution and dispensing is currently the primary objectives for PHE- required drills and FSEs. See Planning Section, Capabilities 8 and 9. Exercise documentation must include AARs, but templates may vary. Interim AARs are acceptable for incidents with prolonged activations or require significant review given the nature of the incident. Final AARs must also be submitted, generally 120 days after deactivation. AARs are preferred but not required for drills. **OPS1.h** Areas for improvement must document lessons from exercises and incidents and ideally within the direct control of the health department to remedy. Specific, measurable, achievable, realistic, and time-bound (SMART) objectives should be written to strengthen operational readiness and address corrective actions. Improvement areas must also align with workforce development training plans. Review WDT3.b-e for consistency. A minimum of one area of improvement must be submitted for each program requirement and must align with corresponding AARs/IPs. For instance, submission of a TTX that also met the requirement of the annual PHEP exercise must include at minimum two areas of improvement, one associated with the TTX and one for the annual PHEP exercise. **OPS1.i** Evidence must indicate EOC activation occurred. At least one area of improvement must be included.	Acceptable Evidence • AARs. • Incident corrective actions. • Training plans with exercise participation included.	At minimum, submit annually; **every EOC activation** involving public health must be entered. Real-time entry is highly encouraged.

Element	Date Entry Guidance	Significance
OPS2.a-u *PHEP program requirements* *a. EOC activation,* *b. Facility setup drill (FSD),* *c. Site activation drill (SAD),* *d. Staff notification and assembly drill (SNA),* *e. Dispensing throughput drill (DTD)*,* *f. Anthrax tabletop exercise (TTX)*,* *g. Pandemic influenza TTX*,* *h. Administrative preparedness TTX*,* *i. Incident management COOP TTX** *j. Laboratory COOP TTX*,* *k. Annual PHEP exercise with vulnerable populations or AFN partners (Par),* *l. Joint functional exercise (FE) with emergency management and HCC (Par)*,* *m. Pandemic influenza: Critical workforce group FE (CWG)*,* *n. Anthrax: distribution FSE (DST)*,* *o. Anthrax: dispensing FSE (DSP),** *p. Pandemic influenza: FSE (PAN)*,* *q. PHEP-funded LRN-B samples testing (LAB),* *r. PHEP-funded LRN-C samples testing using core methods (LAB),*	Select the PHEP program requirement; reviewer guidance indicates the jurisdictions responsible for reporting. Training submissions for drills and exercises should align with the WDT, IPPW, and multiyear IPPs. **OPS2.a** The 62 PHEP recipients and local CRI-funded jurisdictions must report all EOC activations. If there is no incident activation, one SAD for the EOC must be conducted and submitted. If the latter, select both EOC activation and SAD for program requirements. **OPS2.b** FSD for DFLs, CRIs, and TFAS. **OPS2.c** SAD for DFLs, CRIs, TFAS; for states, see also OPS2.a to fulfill an EOC activation. **OPS2.d** Staff notification and assembly drill for states, DFLs, CRIs, TFAS. **OPS2.e** DTD for DFLs, TFAS, and CRIs. **OPS2.f** Anthrax TTX for states, DFLs, and CRIs; TFAS can complete either an anthrax or pandemic influenza scenario. **OPS2.g** Pandemic TTX for states, DFLs, and CRIs; TFAS can complete either an anthrax or pandemic influenza scenario. **OPS2.h** Administrative preparedness TTX for states, DFLs, and TFAS. **OPS2.i** Incident management COOP TTX for states, DFLs, and TFAS). **OPS2.j** Laboratory COOP TTX for states, DFLs, and TFAS. **OPS2.k** Include partners in annual PHEP exercise requirement for states, DFLs, CRIs, and TFAS. **OPS2.l** Joint FE with emergency management and HCCs for states, DFLs, and TFAS. **OPS2.m** CWG pandemic vaccination minimum FE requirement for states, DFLs, and CRIs. This five-year requirement can also be met with CWG vaccination during an incident. Select this program requirement to document COVID-19 response activity involving vaccination for CWG. **OPS2.n** DST is a minimum FSE requirement for states and DFLs. The five-year distribution requirement can also be met with an incident.	CDC requires PHEP recipients to meet annual and five-year program requirements. To meet these requirements, recipients must adopt an HSEEP framework in planning and exercising to ensure consistent and interoperable approach to improvement planning.

Element	Date Entry Guidance	Significance
s. PHEP-funded LRN-C chemical samples testing using additional methods (LAB,) *t. PHEP-funded LRN-C labs SPaSE (LAB), and* *u. PHEP 24/7 bidirectional emergency contact drill (LAB).* **Five-year program requirement.*	**OPS2.o** DSP is a minimum FSE requirement for DFLs, and CRIs. The five-year dispensing requirement can also be met with an incident. **OPS2.p** Pandemic influenza exercise is a minimum FSE requirement for states, DFLs, CRIs, and optional for TFAS. FSE credit can also be met with an incident. Select this program requirement to document COVID-19 response activity not involving CWG vaccination. See OPS2.m. **OPS2.q** PHEP-funded LRN-B sample testing required for states, Los Angeles County, New York City, and Washington D.C. **OPS2.r** PHEP-funded LRN-C sample testing using core methods required for states, Los Angeles County, New York City, and Washington D.C. **OPS2.s** PHEP-funded LRN-C sample testing using additional methods required for states, Los Angeles County, New York City, and Washington D.C. **OPS2.t** PHEP-funded LRN-C SPaSE required for states, Los Angeles County, New York City, and Washington D.C. **OPS2.u** PHEP 24/7 bidirectional emergency contact drill required for states, Los Angeles County, New York City, and Washington D.C.	

Reviewer Guidance	Required Documentation	Submission Frequency
OPS2.a Documentation for every EOC activation involving public health is required for states, DFLs, TFAS, and local CRI-funded planning jurisdictions; documentation for EOC activation for local planning jurisdictions is highly recommended but not required. Information about activations must be entered for OPS1.a-j in real-time; if states do not have an incident activation, a Site Activation Drill of the EOC is allowed. See SAD1a-f. The AAR submission date is auto-calculated (Ops1g) to indicate approximately when the AAR is expected. EOC activations must be acknowledged after the areas of improvement are submitted (Ops1h).	AARs or other evidence is preferred but not required for drills or initial EOC activation submissions. Acceptable Evidence for TTX, FE, FSE, Incidents, or Events • AARs (not required for drills). Acceptable Evidence for Laboratory Exercises • LRN and Association of Public Health Laboratories (APHL) provide evidence of lab reporting Submitted activities are conditional until reviewer verifies them.	At a minimum, submit annually; **every EOC activation** involving public health must be submitted. Real-time entry is highly encouraged. *Indicates five-year program requirement, which is conducted and reported once every five years, at a minimum. Actual incidents or events that fill the criteria for a five-year requirement may be used in lieu of an exercise.

Reviewer Guidance	Required Documentation	Submission Frequency
OPS2.b-u Specific guidance and **acceptable evidence** for each program requirement follows. Each activity must have at least one associated program requirement, including EOC activation at a minimum.		

Facility Setup Drill (FSD)

Element	Data Entry Guidance	Significance
FSD1.a-g *Facility Setup Drill* *a. Type of facility (EOC, RSS, RDS/LDS, POD, DVC, congregate/shelter sites),* *b. Name of facility,* *c. Extent of advanced notification (full, partial, none),* *d. Target time for set up (in minutes),* *e. Facility setup start date/time,* *f. Facility setup end date/time, and* *g. Setup completion time*	**DFL (required), CRIs/local planning jurisdictions (optional)** **FSD1.a-g** Record results from the facility setup. Enter all information for **each** facility that was exercised. This drill requirement can be met with any exercise, incident, or event. Jurisdictions must practice different facility setups and choose different locations and types annually by rotating through sites. Jurisdictions should use a drill response scenario and the national standards for public health capabilities as guides to establish a target time for facilities to be fully operational. Target times will be specific to the facility type mobilized. At least two facility types must be set up when conducted as part of an FSE.	The FSD goal is to determine the time required to prepare a site to support an MCM operational response function. This drill requires a physical operation and setting up all necessary equipment and supplies at an identified site. Facility setup is a crosscutting capability applicable to a wide variety of MCM functions, including dispensing, warehousing, and command and control, among others. Proper setup is an essential condition of a rapid and effective response and can affect the jurisdiction's ability to dispense MCMs to its population within the designated timeframe.

Reviewer Guidance	Required Documentation	Submission Frequency
FSD1.a Jurisdictions must rotate facility setups and use different locations and facility types including PODs, RSS facilities, and RDS/LDS; at least one facility must be set up annually. If PODs have multiple layouts, different configurations must be exercised as relevant given the annual rotation. Since ESF-6 generally has the lead for congregant sites or shelters, collaboration with ESF-6 for shelter facility setup exercises should occur to verify access and functional need compliance. This includes accommodations for mobility and language barriers. Setting up of one type of facility does not meet the standard for this activity when exercised as part of an FSE. **FSD1.b** Review facility name for consistency. Jurisdictions must enter names for the facility setup consistent with any naming conventions previously submitted about a site such as general POD information, RSS, or other documented facilities. See CAP8.5, CAP9.2. **FSD1.c** Review the notification protocol. Each type of notification procedure, no-notice, partial notice, or full notice, must be drilled over the performance period. CDC encourages rotating the type of notification between facilities and locations with each drill. **FSD1.d-g** Target times will be specific to the jurisdiction and the facility type mobilized. Review the practicality of the target time and discuss any significant changes between drill results for like facility drills. If target time is not met, determine whether issues must be addressed in the action plan for improvement.	If an AAR is available for the drill, provide as evidence. Meeting minutes or other evidence of drill is acceptable. <u>Acceptable Evidence</u> • AARs. • Call logs. • Corrective actions. • Drill summary sheets. • Meeting logs with partners identified. • Memos for the record. • Training plans with partner participation documented.	At a minimum, submit annually.

Site Activation Drill (SAD)

Element	Data Entry Guidance	Significance
SAD1.a-h *Site Activation Drill* *a. Type of site activated (EOC, RSS site, RDS/LDS, POD, DVC, congregate/shelter),* *b. Extent of advanced notification (full, partial, none),* *c. Type of site availability (physical, virtual, hybrid),* *d. Target time for availability (in minutes),* *e. Date and time first site notified,* *f. Date and time last site acknowledged notification,* *g. Total number of site(s) that acknowledged notification, and* *h. Completion time.*	**SAD1.a-h** Record results from the site activation drill. Enter all information for each site that was exercised. This drill requirement can be met with any exercise, incident or event. Jurisdictions must practice different site activations and must choose different site types annually and rotate through sites. However, two sites must be activated when drilling a POD/DVC, and PODs/DVCs must be included in annual drills every other year. Indicate if site availability was physical, virtual, hybrid, or if only a site call-down occurred. Jurisdictions should use a drill response scenario and the national standards for public health preparedness capabilities as guides to establish a target time for facilities to be fully operational. Target times will be specific to the site type activated. At least two site types must be activated when conducted as part of an FSE.	The site activation drill evaluates a jurisdiction's ability to contact operational site owners, operators, or points of contact to make an activation notification and assess the time required to ready these sites, which include RDS warehouses, PODs, and EOCs, for operation. Site notification, acknowledgment, and activation are crosscutting capabilities that serve critical functions in a wide variety of emergency response situations and encompass multiple MCM functions, including dispensing, warehousing (RSS/RDS), distribution, security, command center management, and others. Ability to open and activate various types of distribution and dispensing facilities is a required PHEP drill.

Reviewer Guidance	Required Documentation	Submission Frequency
Evaluating site activation tests the notification processes and measures how quickly feedback about site availability is received. **SAD1.a** Review site name for consistency. Jurisdictions must enter site names consistently with any naming conventions previously submitted. Type of site activated must vary annually to include EOC, RSS site, RDS/LDS, POD, or DVC. At a minimum, one site must be activated, but the intent of this drill is to assess the total number of sites included across a facility category. However, two sites must be activated when drilling a POD/DVC, and PODs/DVCs must be included in annual drills every other year. The total number of sites included in the activation drill, by facility-type, must be documented. Activation of one type of site does not meet the standard for this activity when exercised as part of an FSE. **SAD1.b** Review the notification protocol. Each type of notification procedure must be drilled over the performance period (no-notice, partial notice, or full notice). Review the drill history to assure varied exercise scenarios are used to test site activations. **SAD1.c** Drill can be physical, virtual, or hybrid where a portion of the sites is physical, and others are notional or a combination. Review the drill history to assure physical type of site availability is practiced for key sites during the performance period. **SAD1.d** Target times will be specific to the jurisdiction and the site assembled. Review the practicality of the target time and discuss any significant changes between drill results for like sites. If the target time is not met, determine whether issues must be addressed in the action/improvement plan. **SAD1.e-g** Verify accuracy of the data entry. For each operational site category, the jurisdiction must capture the number of sites that acknowledged the message notification and the number of sites that reported the location is ready by the target time. **SAD1.h** Verify accuracy of the data entry. Availability completion time is calculated based on number of site contacts acknowledging receipt of emergency notification.	If an AAR is available for the drill, provide as evidence. Data collection call sheet, if available, should include site call-down completion time, acknowledgement completion time, and percentage of staff and site availability.	At a minimum, submit annually.

Staff Notification and Assembly Drill (SNA)

Element	Data Entry Guidance	Significance
SNA1.a-k *Staff Notification and Assembly Drill* *a. Date and time first person notified,* *b. Date and time last person acknowledged notification,* *c. Extent of advanced notification (full, partial, none),* *d. Incident management roles (or equivalent lead roles) activated (select all that apply),* *e. Target time for assembly (in minutes),* *f. Type of staff assembly (call down only – no assembly, physical, virtual, both),* *g. Date/time last person assembled,* *h. Total number of staff who assembled,* *i. Total number of staff who assembled within target time period,* *j. Staff acknowledged completion time, and* *k. Staff assembly completion time.*	**States, DFL, and Puerto Rico (PR) (required): Drill must be no notice with key incident management staff assembled in 60 minutes or less to receive annual drill credit.** Record results from staff notification and assembly drill. This drill requirement can be met with any exercise, incident, or event. **CRIs and other TFAS (required):** No level of advanced notification or delineated incident management staff are specified to meet the requirement. **SNA1.a** Enter date and time first person notified. **SNA1.b** Enter date and time last person acknowledged notification. **SNA1.c** Enter the type of notification. No notice must be used to receive annual credit for this drill. **SNA1.d-f** Six key incident command staff must be assembled in 60 minutes or less to receive annual credit for this drill: incident commander, operations section chief, planning section chief, logistics section chief, finance or administration section chief, and the PIO. The jurisdiction should establish target times for full staff assembly at the assigned functional location based on standards for that specific site. **SNA1.g-k** Record results from staff notification and assembly drill.	The staff notification, acknowledgment, and assembly drill is conducted to evaluate the jurisdictions' ability and timeliness in contacting staff from different operational categories that the jurisdiction would mobilize during a public health emergency. This drill documents the time to notify staff of emergency operations, the time for staff to acknowledge the notification message, and the percentage of staff that can assemble (report for duty) at their assigned operational locations within a predetermined target time. Importantly, the jurisdiction can collect data from a notional scenario or an actual staff assembly drill to determine staff assembly capability. Staff notification, acknowledgment, and assembly drills are crosscutting capabilities that serve critical functions in a wide variety of emergency response situations and encompass multiple MCM functions, including dispensing, warehousing (RSS/RDS), distribution, security, command center management, and others.

Reviewer Guidance	Required Documentation	Submission Frequency
Verify accuracy of the data entry. Credit for the drill (or incident) is earned when it is a no-notice, immediate assembly of six key incident command roles assembled in 60 minutes or less. Check accuracy of staff rosters, timeliness of staff confirmation to the notification, and staff ability to report for duty in the targeted timeframe. **SNA1.a-b** Review total number of staff, type of staff, and time required to distribute notification to emergency response staff. **SNA1.c** No-notice notification is the most advanced and incident-specific situation. Not all emergencies require no-notice assembly, but it is required for annual drill credit. **SNA1.d-f** Review the jurisdiction's ability to mobilize a full complement of staff resources to support an operational activity. Type of staff notified for assembly can include those supporting EOC, RSS, RDS/LDS, POD, or DVC sites. However, credit for the annual drill must include assembly of the following six key incident management roles in 60 minutes or less: incident commander, operations section chief, planning section chief, logistics section chief, finance or administration section chief, and the PIO. Use discretion to determine the feasibility of the jurisdiction to support multiple command roles with distinct individuals; it might be necessary to give credit if multiple roles are filled by one individual, for instance in small jurisdictions. Target time, in minutes for full staff assembly is determined by the jurisdiction given the specific site activated. If the target time is not met, determine whether issues must be addressed in the action plan for improvement. **SNA1.g-i** Jurisdiction must capture the number of people that acknowledged the message and the number of staff members who report they can assemble at the identified location within the target time. Review the drill history and encourage rotation of the various types of staff assembly (physical, virtual, or both) over the budget period. **SNA1.j** Verify accuracy of the data entry. Staff notification completion time is calculated based on the difference in date/time between the first and last person acknowledging the notification. **SNA1.k** Verify accuracy of the data entry. Staff assembly completion time is calculated based on the difference in date/time between the first to last person assembled.	If an AAR is available for the drill, provide as evidence. Acceptable Evidence • AARs. • Call down rosters. • Call logs. • Corrective actions. • Drill summary sheets. • Meeting logs with partners identified. • Memos for the record. • Training plans with partner participation documented.	At a minimum, submit annually; TFAS are required to submit every five years, at a minimum.

Dispensing Throughput Drill (DTD)

Element	Data Entry Guidance	Significance
DTD1.a-j *Dispensing Throughput Drill* *a. Extent of advanced notification (full, partial, none),* *b. Number of facilities set up,* *c. Name of facility (per facility),* *d. Type of facility (POD, DVC),* *e. Total number of people or vehicles processed through facility (enter per facility),* *f. Open or closed facility,* *g. Walk or drive through (for PODs),* *h. Traditional/assisted or express dispensing,* *i. Delivery method (oral, vaccine, other), and* *j. Target time for set up (in minutes).*	**DTD1.a-j** Record DTD results. This drill requirement can be met with a dispensing FSE, an incident, or an event that dispensed MCMs. This requirement must be met every five years. At minimum, one POD per CRI planning jurisdiction must drill dispensing procedures. Throughput calculations must consider number of regimens dispensed to head of household (HoH), traditional or assisted or express dispensing information, total time for each individual to start and complete dispensing activities, regimens per hour (required data entry), persons per hour (required data entry), and average completion time (required data entry).	The DTD tests dispensing procedures and verifies estimates of regimens (or courses) allotted to persons per hour for each POD layout.

Reviewer Guidance	Required Documentation	Submission Frequency
Verify accuracy of the data entry. **DTD1.a** While notification type is not specified, review the history of throughput drills and encourage jurisdictions to practice all types. **DTD1.b** Although not required, inclusion of multiple PODs or DVCs allows for better estimate of jurisdictional capacity. Review drill history and encourage jurisdictions to drill throughput for various POD/DVC footprints to fully represent the jurisdictions plans for dispensing. **DTD1.c-j** Review information per facility drilled. Naming conventions must match any facility information previously submitted. See CAP8.5 to crosswalk POD detail.	If an AAR is available for the drill, provide as evidence. Acceptable Evidence • AARs. • Call logs. • Corrective actions. • Drill summary sheets. • Meeting logs with partners identified. • Memos for the record. • Training plans with partner participation documented.	At a minimum, submit once every five years.

Tabletop Exercise (TTX) – Anthrax TTX, Pandemic Influenza TTX, Administrative Preparedness TTX, Incident Management COOP TTX, Laboratory COOP TTX

Element	Data Entry Guidance	Significance
TTX1.a-f *Tabletop Exercise* *a. List jurisdictions that participated,* *b. Dispensing/distribution topics addressed,* *c. Pandemic topics addressed,* *d. Pandemic interval,* *e. Fiscal or other administrative processes and procedures included, and* *f. COOP processes and procedures included.*	Record results for TTX. This requirement can be met with any exercise or an incident but cannot be the same activity used to fulfill the FSE requirements. For instance, when reporting a large-scale response, such as COVID-19, credit may be obtained to meet the pandemic FSE requirement but cannot be obtained to meet both pandemic TTX and pandemic FSE requirements. **TTX1.a** Record any regional, district, ward, parish, local, and/or federal partners that participated. **TTX1.b Question appears only for anthrax TTX.** Select relevant dispensing/distribution topics discussed for the anthrax TTX. Topic Options: primary and backup warehouse storage capacity, warehouse and transport security including adaptability and scalability, and warehouse throughput time; cold-chain storage capacity; cold-chain storage temperature monitoring; inventory management; trucks and drivers for sustainable 24-hour operation, capacity to transport to dispensing sites in 12 hours, scalability of warehouse plans, RSS site, RDS/LDS, POD staffing sufficiency in numbers and training; security forces designated for POD-specific plan; number and location of PODs; crisis and emergency risk communications; public health responder prophylaxis; hospital data sharing; or other. The TTX must be distinct from the submitted dispensing FSE and the distribution FSE, as the same activity cannot be credited twice to fulfill program requirements. **TTX1.c-d Questions appears only for pandemic influenza TTX.** Select pandemic influenza topics discussed from the following list and select the pandemic influenza interval covered by the TTX scenario. **TTX1.c.** Topic Options: antimicrobial and antiviral drugs; collaboration with clinical laboratories; contact tracing; crisis and emergency risk communication; critical workforce registration and certification; critical workforce training; critical workforce vaccination; detection of novel influenza A; epidemiological investigations; epidemiology information sharing; hospital data sharing; immunization information systems (IIS); isolation; laboratory specimen transport, surge; movement restrictions; pandemic vaccine; PPE; quarantine; school closures; SME roles and responsibility; social distancing; tracking for regulatory requirements; ventilators; or other. **TTX1.d** Phase Options: investigation, recognition, initiation, acceleration, deceleration, and preparation The pandemic influenza TTX must be distinct from the submitted pandemic influenza FSE, as the same activity cannot be credited twice to fulfill program requirements.	TTX requirements are an important step in the progressive approach to multiyear exercise planning encouraged by HSEEP. Focusing on various response scenarios allows participants to generate a dialogue with various partners, and facilitate a conceptual understanding, as well as identify strengths and potential areas for improvement.

Element	Data Entry Guidance	Significance
	TTX1.e Question appears only for administrative preparedness Select the relevant fiscal and administrative preparedness topics discussed. Topic Options: administrative systems; budget management; contracts including cycle time to secure; financial reporting; grants allocation; hiring surge including staffing or reassignment considerations; procurement time; receiving emergency funds following jurisdiction's emergency declaration or order; regulations; or other. This requirement can be met with any exercise, incident, or event. **TTX1.f Question appears only for COOP TTX.** Select the relevant incident management or laboratory COOP topics discussed. Topic Options: alternate or virtual worksites; essential services such as EOC, LRN-B, or LRN-C; human capital management; scalable workforce including expansion and reduction; procedures for regular maintenance of redundant testing supplies; processes to designate alternate testing facilities for short-term duration in case of localized infrastructure failure; agreements with other agencies to take over critical testing; procedures to address personnel shortages; procedures to address equipment failures; procedures to address operational loss of laboratory facilities; or other. This requirement can be met with any exercise, incident, or event.	

Reviewer Guidance	Required Documentation	Submission Frequency
For each TTX requirement, review generally the agenda for purpose, structure, goals, and outcomes. TTXs are intended to generate discussion among participants across pertinent topics given an exercise scenario, and a TTX should enhance general awareness about plans, procedures, and partner roles and responsibilities. Planned drills and exercises must be included on the WDT. **TTX1.a** Review the TTX participants. While there is no requirement for participants, generally state, local, regional, federal, and tribal partner attendance is encouraged. **TTX1.b** An anthrax TTX must be based on an intentional release scenario. Review AAR or equivalent documentation for topics discussed and identified improvement areas for distribution and dispensing. Crosswalk with CAP8 and CAP9 evidence. At least one improvement area must be submitted and align with documentation. **TTX1.c-d** A pandemic influenza TTX must address some aspect of protection, mitigation, response, or recovery for a simulated pandemic influenza scenario. The pandemic interval must be included to accurately identify exercise goals given relevant tasks and functions. See Pandemic Intervals Framework. Review AAR or equivalent documentation for topics discussed. At least one improvement area must be submitted and align with AAR documentation. **TTX1.e** An administrative and fiscal TTX must address issues relevant to the jurisdiction's planning priorities. Review AAR or equivalent documentation for topics discussed. At least one improvement area must be submitted and align with documentation. **TTX1.f** A COOP TTX must address processes to maintain essential services. Focus may include discussions on scalable workforce, alternate or virtual worksites, devolution, reconstitution of essential services, or other topics relevant to the jurisdiction's planning priorities. Review AAR or equivalent documentation for topics discussed. At least one improvement area must be submitted and align with documentation.	Acceptable Evidence • AARs. • Incident corrective actions. • Training plans with exercise participation included.	At a minimum, submit once every five years.

Annual PHEP Exercise (Vulnerable Populations) with Access and Functional Needs (AFN) Partners and Joint Functional Exercise with Emergency Management and Health Care Coalitions (PAR)

Element	Data Entry Guidance	Significance
PAR1 *Annual PHEP exercise with vulnerable populations or AFN partners.*	Record information about CMIST partners that participated in the exercise. This requirement can be met with any exercise, incident, or event. **PAR1** Indicate which partners identified on the PPS participated in the activity. See PPS1.a.	Jurisdictions must adopt a whole community planning approach. Consistent with Capability 1: Community Preparedness, training and participation in exercises, incidents, and events help solidify roles and increase knowledge and support for community involvement in preparedness efforts. Partners involved in response and recovery should be actively engaged in training and exercises.

Reviewer Guidance	Required Documentation	Submission Frequency
Verify accuracy of the data entry. **PAR1** Credit for the annual PHEP exercise requirement requires that evidence documents engagement with CMIST partners or other stakeholders representing people with disabilities and others with AFNs. At least one partner must participate in the TTX; crosswalk evidence with PPS. Partners supporting people with AFN must be documented on the PPS. Credit toward the annual PHEP exercise with vulnerable populations can be granted if at least one partner that represents AFN groups was involved in the exercise such as older adults; children and youth; people with chronic illness and disabilities; people experiencing homelessness and transportation instability; or people with language barriers.	Acceptable Evidence • AARs. • Incident corrective actions. • Participant logs. • Training plans with exercise participation included.	At a minimum, submit annually.

Element	Data Entry Guidance	Significance
PAR2 *Exercised accommodations for persons with AFN.*	**PAR2** Indicate what accommodations for people with AFN were implemented.	All facilities managed in whole or part by public health agencies must address the needs of the whole community including individuals with AFN. Exercising facilities including PODs, DVCs, and congregate sites with AFN partners prior to emergencies can identify potential barriers.

Reviewer Guidance	Required Documentation	Submission Frequency
PAR2 Emergencies can intensify existing vulnerabilities and create new ones. Rather than isolating people with vulnerabilities and disabilities, the CMIST framework helps identify additional needs that must be considered when planning for, responding to, and recovering from a disaster or emergency. Review evidence for facility setup considerations that address people with limitations receiving and responding to information, requiring personal assistance, assistive devices, consumable medical supplies, or durable equipment. Evidence must address how language barriers, cognitive impairment, or vision or mobility issues can be accommodated at the facility. Other considerations should be for provision of service animals, pregnant or nursing woman, infants, children, and other people potentially susceptible to being disproportionately impacted by the incident. Credit toward the annual PHEP exercise requires inclusion of at least **one** accommodation focused on improving AFN accommodations for **annual** PHEP exercise credit. **At least three** accommodations must be included for **FSE** credit; if not, document this as an area for improvement.	To meet the annual requirement using a drill or FE, **at least one example** of an implemented accommodation is **required** for each identified AFN partner. If a TTX is used to meet the annual requirement, evidence based on the discussion of **at least one improvement** that modifies an accommodation by a participating partner is required. For five-year FSE requirement, at least **three examples** of implemented accommodations are **required** for each partner indicated as representing an access and functional needs partner. Examples of Accommodation Documentation (examples are not exhaustive) • Messages for whole community including AFN population that are written in simple language and large fonts. • Facility materials such as signage and handouts that accommodate communication barriers such as language and literacy. • Photos that document accommodations for persons with mobility issues. Other Acceptable Evidence • AARs. • Call logs. • Corrective actions. • Drill summary sheets. • Meeting logs with partners identified. • Memos for the record. • Training plans with partner participation documented.	At a minimum, submit annually.

Element	Data Entry Guidance	Significance
PAR3.a-b *Joint exercise with emergency management and HCC* *a. Participating partners and* *b. HHS regional participation (select all that apply).*	Record information about HCCs and emergency management partners that participated in the exercise. At a minimum, this requirement can be met with an FE, but it can also be demonstrated during an FSE, an incident, or an event. **PAR3.a** Record participating HCC and emergency management partners. These partners must also be on the PPS. **PAR3.b-c** Select all HHS regional partners that participated.	Collaboration between public health, health care systems, and emergency management facilitates coordination between agencies that support health care. These exercises build familiarity between stakeholders involved in emergency response that impacts public health.

Reviewer Guidance	Required Documentation	Submission Frequency
Verify accuracy of the data entry. Public health does not have to be the lead organization for the exercise. **PAR3.a-b** Evidence must document inclusion of at least **one emergency management and one HCC partner**. At this level of exercise, partner roles and responsibilities must be demonstrated rather than simply discussed as with a TTX. At a minimum, the partner must be included as a participant in the partner section of AAR or equivalent documentation. Relevant HHS regional participation must also be evident. Crosswalk documentation or partner participation is documented on the PPS.	Acceptable Evidence • AARs. • Incident corrective actions. • Participant logs. • Training plans with exercise participation included.	At a minimum, submit once every five years.

Pandemic Influenza: Critical Workforce Group FE (CWG)

Element	Data Entry Guidance	Significance
CWG1.a-i *Vaccination of critical workforce requirements* *a. Type of vaccine administered (pandemic influenza, seasonal influenza, novel coronavirus, other),* *b. Method of vaccine administered (vaccinated, simulated, hybrid),* *c. Participating CWG,* *d. Participating staff vaccinated,* *e. SMEs involved (select all that apply),* *f. SME role,* *g. Method of notification of targeted CWG,* *h. Communication platforms used for staff notification, and* *i. Call notification process.*	Record results from CWG FE. Exercising vaccination for prioritized CWGs with at least one CWG is required. The exercise must be conducted in a closed POD/DVC to simulate vaccine control. This requirement can be met with any FE, FSE, incident, or event. Planners should work closely with immunization program counterparts to ensure best practices and procedures for vaccine protocols are followed during the exercise. Jurisdictions should pay close attention to vaccine administration, storage, handling, and reporting. Additionally, collaboration with nontraditional prioritized CWGs such as private sector, utilities, and law enforcement, are encouraged. Finally, this FE must test processes for reporting vaccine dose administration to the IIS. During an incident, data on administered vaccine doses will inform practitioners, public health policy decisions, and ensure patient safety. **CWG1.a** Select the type of vaccine used or assumed to be used if not administered. The type of vaccine selected potentially will impact the number and timing of doses as well as what populations can be vaccinated. If the FE is conducted with a pandemic assumption or during an incident, an Emergency Use Authorization (EUA) might be enacted with specific use conditions. The National Pandemic Influenza Vaccine Stockpile (NPIVS) may also be recommended for use among certain populations as a priming dose. **CWG1.b** Select the method of administration: vaccine, simulated vaccine, or a combination of both, depending on the exercise scenario and intended outcomes. **CWG1.c** Choose the relevant group from the drop-down choices, which are based on CDC's interim updated planning guidance on allocating and targeting pandemic influenza vaccine during an influenza pandemic. **CWG1.d** Indicate whether staff was vaccinated. **CWG1.e-f** Select from the drop-down menu the first SME role included in the exercise and indicate whether the SME was a planning partner, exercise, or incident. participant, or both. Repeat until all roles are entered. **CWG1.g** Select all methods used to notify CWG about the exercise. **CWG1.h** Select relevant communication platforms used or tested; this should align with planning documentation. **CWG1.i** Select type of notification such as automated, manual, or hybrid. This should align with planning documentation.	HSEEP progressive exercise principles include various types of operations-based exercises including the functional exercise. It is designed to test and evaluate capabilities and function in a realistic, real-time environment. At this level of exercise, movement of resources may be notional, but partner roles and responsibilities are performed rather than discussed as with a TTX. The CWG vaccination FE provides information about allocating and targeting vaccine during a pandemic for CWGs. This exercise assumes that in the event of a severe influenza pandemic or similar public health emergency vaccine supply would be limited in the early phase. Refer to CDC pandemic influenza guidance for tools to assist in planning for rapid identification of CWGs.

Reviewer Guidance	Required Documentation	Submission Frequency
Checklist of Best Practices for Vaccination Clinics Held at Satellite, Temporary, or Off-site Locations must be submitted as evidence. **CWG1.a-b** Review evidence for dosage timing based on type of vaccine administered. In a pandemic, provisions for a second dose administration might be required. Evidence must document alignment to federal guidance in that scenario; administration must also comply with any other provisions outlined in an EUA if issued or other pertinent federal guidance. If an exercise is submitted, a combination of methods may be used to complete the exercise **CWG1.c** FE must include at least one group based on CDC's interim updated planning guidance on allocating and targeting pandemic influenza vaccine during an influenza pandemic or federal government prioritization. **CWG1.d-f** Review staff and SME participation. Confirm pertinent staff and SMEs were vaccinated and participated in the exercise as entered. **CWG1.g** Confirm whether notification methods used to notify CWG about the exercise were utilized and tested during the exercise. **CWG1.h** Relevant communication platforms used or tested should align with planning documentation. **CWG1.i** Type of notification such as automated, manual, or hybrid should align with planning documentation.	Acceptable Evidence • AARs. • Checklist of Best Practices for Vaccination Clinics Held at Satellite, Temporary, or Off-site Locations (required). • Incident corrective actions. • Training plans with exercise participation included.	At a minimum, submit once every five years.

Element	Data Entry Guidance	Significance
CWG2.a-e *POD/DVC setup* *a. Name of POD/DVC,* *b. Setup start date and time,* *c. Setup end date and time,* *d. Setup completion time,* *e. Best practices evidence (upload "Checklist of Best Practices for Vaccination Clinics Checklist of Best Practices for Vaccination Clinics Held at Satellite, Temporary, or Off-Site Locations").*	Record results from CWG FE. Exercise vaccination for prioritized CWGs with at least one CWG is required. The exercise must be conducted in a closed POD/DVC to simulate vaccine control during an incident. This requirement can be met with any FE, FSE, incident, or event. **CWG2.a-d** PODs/DVCs used during exercise should align with those reported in CAP8.5. Indicate the setup start and end date and time. For exercises, the start and end date might be the same. **CWG2.e** Upload checklist used during the exercise. Credit for conducting the exercise and identifying improvement areas is given regardless of how many barriers were incurred.	HSEEP progressive exercise principles include various types of operations-based exercises including the FE. It is designed to test and evaluate capabilities and function in a realistic, real-time environment. At this level of exercise, movement of resources may be notional, but partner roles and responsibilities are performed rather than discussed as in a TTX. The CWG vaccination functional exercise provides information about allocating and targeting vaccine during a pandemic for CWGs. This exercise assumes that in the event of a severe influenza pandemic or similar public health emergency vaccine supply would be limited in the early phase. Refer to CDC pandemic influenza guidance for tools to assist in planning for rapid identification of critical workforce groups (CWGs).

Reviewer Guidance	Required Documentation	Submission Frequency
Checklist of Best Practices for Vaccination Clinics Held at Satellite, Temporary, or Off-site Locations must be submitted as evidence. **CWG.2a-d** Naming convention for facility names must match prior submissions. See CAP8.5. Review setup start and stop time given specifications of the location; there is no benchmark for this process. Probe for any setup barriers and review that improvement plans focus on identified barriers. **CWG2.e** Checklist is a step-by-step guide to oversee vaccination clinics held at satellite, temporary, or off-site locations. The checklist follows the CDC guidelines and best practices for patient safety and vaccine effectiveness including vaccine shipment, transport, storage, handling, preparation, administration, and documentation. Review checklist answers and evaluate how the improvement plan addresses "stops" or no responses. Credit is granted for conducting the CWG FE regardless of how many stops are incurred.	Acceptable Evidence • AARs. • Checklist of Best Practices for Vaccination Clinics Held at Satellite, Temporary, or Off-site Locations required. • Incident corrective actions. • Training plans with exercise participation included.	At a minimum, submit once every five years.

Element	Data Entry Guidance	Significance
CWG3.a-i *Immunization information system (IIS* *a. Total number of targeted CWG enrolled prior to FE,* *b. Total number enrolled during FE,* *c. Number of vaccine doses reported to IIS day of FE,* *d. Reported one to seven days after FE,* *e. Reported > seven days after FE,* *f. Total number of doses administered during FE,* *g. IIS vaccine reporting method,* *h. Vaccine history screening (primary method), and* *i. Verify membership in targeted CWG.*	Record results from CWG FE. Exercising vaccination for prioritized CWGs with at least one CWG is required. The exercise must be conducted in a closed DVC to simulate vaccine control during an incident. This requirement can be met with any FE, FSE, incident, or event. **CWG3.a** Take time prior to the day of FE to enroll members of the targeted CWG into the IIS. Enrollment is defined as having a demographic record established in the IIS. Jurisdictions should ensure data from vaccine administration are tracked and rapidly uploaded into their IIS. **CWG3.b** Some CWG members will be enrolled on-site, regardless of planning efforts. **CWG3.c-f** A portion of the administered dosages will be reported on the day of the exercise. Some will report in the week following, and some will come in more than a week after the exercise. These numbers measure timeliness of reporting to IIS. **CWG3.g** Select all that apply to describe timing and type of vaccine reporting; drop-down options include delayed batched entry via flat file transfer, delayed entry (after POD/DVC is closed) of individual doses, direct connection between IIS and electronic medical record system, manual entry, and real time entry of individual doses. **CWG3.h** Select from the drop-down choices or add the method used to screen CWG vaccine history. Drop-down choices include communication with other health care providers, reviewed IIS, reviewed paper records, or reviewed patient's personal documentation. During the FE, staff is encouraged to use IIS, but options can be simulated. Vaccine history is an important factor during a pandemic since it likely will require two doses of vaccine separated by three weeks. **CWG3.i** Confirm each person is a member of targeted CWG.	This FE exercises processes for reporting vaccine dose administration to the IIS. IIS is used to collect and consolidate vaccination data from providers in a geographic area. Reporting vaccinations to IIS is critical for tracking and measuring immunizations and guiding public health actions during outbreaks, especially for immunizations which require multiple doses at specific intervals. Pandemic influenza planning assumes that two doses given 21 days apart may be required for all age groups. In an incident, data on administered vaccine doses will inform practitioners, public health policy decisions, and ensure patient safety.

Reviewer Guidance	Required Documentation	Submission Frequency
Checklist of Best Practices for Vaccination Clinics Held at Satellite, Temporary, or Off-site Locations must be submitted as evidence. **CWG3.a-b** Verify accuracy of the data entry and review improvement plans to decrease same day enrollment. **CWG3.c-g** The majority of vaccine administration reported to the IIS should be same day. When there is a significant discrepancy, method for timely reporting must be further addressed and included in improvement plans. **CWG3.h** Review to verify use of IIS. During the FE staff are highly encouraged to use IIS, but use can be simulated. Actual administration must include verification of vaccine history. **CWG3.i** Review accuracy of rosters for targeted CWG.	Acceptable Evidence • AARs. • Checklist of Best Practices for Vaccination Clinics Held at Satellite, Temporary, or Off-site Locations (required). • Incident corrective actions. • Training plans with exercise participation included.	At a minimum, submit once every five years.

Anthrax Distribution Full-scale Exercise (FSE) (DST)

Element	Data Entry Guidance	Significance
DST1.a-mi *Anthrax distribution FSE requirements* *a. Start date and time,* *b. End date and time,* *bi. Exercise completion time,* *c. RSS facility setup (yes or no):* *ci. RSS facility staff participating,* *cii. RSS security participating,* *d. Number of sites receiving MCMs (include any RDS/LDS, open PODs, closed PODs, health care),* *e. Number of transportation assets mobilized,* *ei. Types of transportation assets mobilized,* *f. Backup transportation used (yes or no),* *fi. if yes, describe inject used to activate backup transport, or situation requiring use of backup transport during an incident,* *g. Procedures for cold chain management (yes or no),* *gi. if yes, describe how cold chain management was exercised or used,* *h. Security plans were demonstrated in the following distribution phases (select all that apply),* *i. Request for federal assets,*	Demonstrate jurisdiction's ability to carry out an antibiotic distribution campaign in response to an aerosolized anthrax event. **DST1.a-b** Enter the start and end date and times of the RSS facility setup if different from the information recorded for the overall activity. **DST1.b.i** Completion time is calculated based on difference between exercise start and end date and time. **DST1.c** Follow guidance for FSD1.a-e. At least one RSS must be activated for this FSE. Activating both primary and backup RSS facilities is highly encouraged. **DST1.c.i-ii** Follow guidance for SNA1.a-j and enter information for all staff who participated in the exercise. Distribution lead, logistics lead, RSS lead, security coordinator, and DEA registrant are required participants. **DST1.d** Provide the total number of sites that receive materiel directly from the RSS facility including RDS, LDS, or others. If no intermediate sites participate, enter "0." **DST1.e-ei** Transportation assets need to be exercised or used in an incident at least once every five years to test capacity and availability. Provide total number of vehicles used for distribution to PODs and intermediate distribution sites. Describe type of vehicles used for distribution to PODs and intermediate distribution sites. Number and load capacity of transportation assets should align with exercise objectives. **DST1.f-fi** If backup transportation is used, briefly describe the inject used to exercise backup transport or the situation requiring use of backup transport during an incident. **DST1.g-gi** Cold chain management capability needs to be exercised or used in an incident at least once every five years to test capacity and availability. Cold chain management must describe methods for storage type, capacity, and temperature-control during transport and storage. **DST1.h** Security plans must be exercised once every five years. Select distribution phases during which security plans were exercised. **DST1.i** The primary RSS facility must be able to receive federal assets for distribution. Enter time federal assets were requested and time assets were received at the RSS facility.	HSEEP progressive exercise principles include various types of operations-based exercises including the FSE. It is designed to test and evaluate capabilities and function in a realistic, real-time environment. At this level of exercise, movement of resources, partner roles and responsibilities are performed rather than discussed as in a TTX.

Element	Data Entry Guidance	Significance
j. RSS facility estimate of warehouse processing time, *k. Total time for distribution (from RSS site to local site)* *ki. RSS warehouse processing completion time.* *l. Date and time the first MCM assets leave the RSS site to the first local site.,* *m. Date and time the first MCM assets leave the RSS site to the last local site* *mi. Total distribution completion time.*	**DST1.j-ki** Enter start and end date and time. Activities occurring during this time must include unloading and staging assets, generating pick lists for all identified receiving locations in the exercise, and loading of transportation assets at the RSS warehouse. **DST1.l-mi** Provide date and time the first MCM assets leave the RSS site and the date and time when the last MCM assets arrive at the last local site expecting delivery.	

Reviewer Guidance	Required Documentation	Submission Frequency
Verify accuracy of the data entry. **DST1.a-b** If more than one EOC is activated during FSE, review all applicable start date and times. Follow reviewer guidance for OPS1.c. **DST1.bi** Completion time is calculated based on difference between exercise start and end date and time. **DST1.c-cii** At least one RSS site must be activated for FSE credit. Follow reviewer guidance for FSD1.a-e and SNA1.a-j. Distribution lead, logistics lead, RSS site lead, security coordinator, and DEA registrant are required participants. **DST1.d** Depending on exercise objectives and the distribution plan, intermediate sites may not be used. Review evidence for accuracy of reported data. **DST1.e-ei** Transportation asset numbers and type must match distribution plans and reported data must align. See CAP9 guidance. Also review to ensure the AAR transportation assets align with exercise objectives. If transportation was inadequate, this must be documented as an area for improvement. **DST1.f-fi** If backup transportation is used, verify the inject. **DST1.g-gi** Review cold chain management; exercise objectives must align with planning documentation per CAP9.6a-c. Cold chain management must describe methods for storage type, capacity, and temperature-control during transport and storage. If cold chain management was inadequate, this must be documented as an area for improvement. **DST1.h** Security plans must be exercised once every five years. Review evidence to document security plan objectives were exercised for the distribution phases selected.	Acceptable Evidence • AARs. • Incident corrective actions. • Training plans with exercise participation included.	At a minimum, submit once every five years.

Reviewer Guidance	Required Documentation	Submission Frequency
DST1.i Federal assets must be requested. The current target for receipt of federal MCM assets is within six hours of a request. If delivery exceeded the six-hour window, this must be documented as an area for improvement. **DST1.j-ki** Review the warehouse processing. The estimated time measures the unloading and staging of assets, number of staff and time to generate pick lists for requested material and loading of all transportation assets for delivery to all activated receiving sites. If warehouse processing was inadequate, this must be documented as an area for improvement. **DST1.l-mi** Review total time for warehouse processing per DST1.i and assets to arrive at identified receiving sites. Target time should be 12 hours or less from the overall processing at the warehouse to the last local receiving site. If warehouse processing was inadequate or more than 12 hours, this must be documented as an area for improvement.		

Anthrax: Dispensing FSE (DSP)

Element	Data Entry Guidance	Significance
DSP1.a-d Anthrax dispensing FSE requirements a. *Public health responders used to run PODs/DVCs (yes or no),* b. *Staff received initial prophylaxis as part of exercise or incident (yes or no),* c. *SMEs involved (select all that apply), and* d. *PODs/DVCs participating in exercise or incident.*	Demonstrate jurisdiction's ability to carry out an antibiotic distribution campaign in response to an aerosolized anthrax event. **DSP1.a** Indicate responder participation in POD operations. **DSP1.b** Indicate whether the staff received actual prophylaxis as part of exercise. **DSP1.c** Select all SMEs involved in planning or the exercise. If the activity is an incident or an event, select all SMEs who were consulted or involved. **DSP1.d** Indicate all PODs/DVCs (open/closed) included in the exercise or incident. POD names must match information entered in CAP8.5.	HSEEP progressive exercise principles include various types of operations-based exercises including the FSE. It is designed to test and evaluate capabilities and function in a realistic, real-time environment. At this level of exercise, movement of resources, partner roles and responsibilities are performed rather than discussed as in a TTX.

Reviewer Guidance	Required Documentation	Submission Frequency
Verify accuracy of the data entry. **DSP1.a** Review evidence for whether POD staffing supported the exercise functions and objectives. If staffing was inadequate, this must be documented as an area for improvement. **DSP1.b** Review exercise objectives and playbook for information about whether actual administration of prophylaxis was planned. If exercised, determine whether issues must be addressed in the action plan for improvement. **DSP1.c** For all SMEs involved, verify role to extent possible by reviewing submitted evidence. **DSP1.d** Review PODs/DVCs included in the exercise or incident. Encourage rotation of PODs/DVCs use for exercises overtime.	Acceptable Evidence • AARs. • Attendance logs for assessment or planning meetings. • Example messages developed during incident/exercise. • Incident corrective actions. • Training/evaluation plans with exercise participation included.	At a minimum, submit once every five years.

Element	Data Entry Guidance	Significance
DSP2.a-c For each POD *a. Name of POD,* *b. List current POD first shift management or lead staff, and* *c. Security staff exercised (yes or no); if yes, number of security staff who participated.*	Demonstrate jurisdiction's ability to carry out an antibiotic distribution campaign in response to an aerosolized anthrax event. **DSP2.a-c** Complete for at least two PODs/DVCs. Follow guidance for FSD1a-f, SAD1.a-h, SNA1.a-i, DTD1.a-j, and PAR1-2 to complete requirements for FSE credit.	HSEEP progressive exercise principles include various types of operations-based exercises including the FSE. It is designed to test and evaluate capabilities and function in a realistic, real-time environment. At this level of exercise, movement of resources, partner roles and responsibilities are performed rather than discussed, as in a TTX.

Reviewer Guidance	Required Documentation	Submission Frequency
Verify accuracy of the data entry. **DSP2.a-c** Verify accuracy of POD detail and alignment with CAP8.5. Follow guidance for FSD1a-f, SAD1.a-h, SNA1.a-i, DTD1.a-j, and PAR1-2 to complete review for FSE credit. At least two PODs must be exercised and at least **three** accommodations (PAR1-2) must be included for FSE credit; if not, this must be documented as an area for improvement.	Acceptable Evidence • AARs. • Attendance logs for assessment or planning meetings. • Example messages developed during incident/exercise. • Incident corrective actions. • Training/evaluation plans with exercise participation included.	At a minimum, submit once every five years.

Pandemic Influenza: FSE (PAN)

Element	Data Entry Guidance	Significance
PAN1.a-f *Pandemic FSE: COVID-19 requirements* *a. Community Resilience,* *b. Incident Management,* *c. Information Management,* *d. Countermeasures and Mitigation,* *e. Surge Management, and* *f. Biosurveillance.*	Demonstrate jurisdiction's ability to exercise or respond to an actual pandemic in each of the domains described in the Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health . **For each domain (PAN1.a-f), provide substantive evidence that demonstrates implementation of applicable activities given the exercise objectives or the response context.** **PAN1.a** Evidence must illustrate the pandemic exercise or response reinforced **Community Resilience** by demonstrating a minimum application of **Capability 1: Community Preparedness or Capability 2: Community Recovery** principles. Documentation must show how prioritized populations, those potentially disproportionality impacted, were accommodated during the response. Evidence from the exercise or incident must include at a minimum **one** example from the list below. • Evidence about how faith-based organizations, community-based organizations, racial and ethnic minority groups, schools and childcare, retirement communities, correctional populations, tribal communities, or other identified AFN populations were included. • Evidence that transportation assets were used to support the needs of residents with AFN. See CAP1.2. • Evidence that a trusted spokesperson or equivalent representing AFN partners participated in the exercise or incident and delivered public health messages. See CAP1.3. • Evidence that availability of public health, environmental health, or mental/ behavioral services was provided during the exercise or incident. See CAP2.1a-f. • Evidence that the public was notified about available services during the exercise or incident. See CAP2.2. **PAN1.b** Evidence must illustrate the **Incident Management** domain by demonstrating **Capability 3: Emergency Operations Coordination** was sustained during the pandemic exercise or response. The health department must participate in the exercise or be substantially involved in a pandemic response incident with public health implications. See OPS1.a-i. Evidence from the exercise or incident must include at a minimum **one** example from the list below. • Documentation that additional personnel or assets were acquired during the exercise or incident. See CAP3.4.	HSEEP progressive exercise principles include various types of operations-based exercises including the full-scale exercise. It is designed to test and evaluate capabilities and function in a realistic, real-time environment. At this level of exercise, movement of resources, partner roles and responsibilities are performed rather than discussed as in a TTX. The capability standards are organized into six domains and two tiers. Tier 1 capability standards form the foundation for public health emergency preparedness and response. Tier 2 capability standards are more crosscutting, and development relies upon having Tier 1 capability standards established in collaboration with external partners and stakeholders. Demonstrating capability function is the core emphasis for the pandemic FSE.

Element	Data Entry Guidance	Significance
	• Documented activities for incident command management and staffing such as staff training and mobilization, emergency resource procurement, or task tracking was implemented during the exercise or maintained for a minimum of two weeks during an incident. See CAP3.5a-d. • Documentation that COOP plans were implemented. See CAP3.6a-d. **PAN1.c** Evidence must illustrate the **Information Management** domain by demonstrating the pandemic exercise or the response maintained **Capability 4: Emergency Public Information Warning** or **Capability 6: Information Sharing.** Evidence from the exercise or incident must include at a minimum **one** example from the list below. • The establishment or participation in a JIC. See CAP4.2a-c. • The ability to develop, coordinate, and disseminate information, alerts, warnings, and notifications to the public and incident management personnel was demonstrated during the exercise or response. See CAP4.3a-c. • Public or media inquiries were addressed during the exercise or incident. See CAP4.4a-b. • Partners were engaged in key communications during the exercise or incident. See CAP6.1a-b and PPS1. • Information about situational awareness among multijurisdictional (federal, state, local, tribal, or territorial levels) or multidisciplinary partners including the private sector were exchanged during the exercise or response. See CAP6.2a-c. **PAN1.d** Evidence must illustrate the **Countermeasures and Mitigation** domain by demonstrating the pandemic exercise or the response maintained evidence of **Capability 11: Nonpharmaceutical interventions (NPI)** (**required**). • Evidence from the exercise or incident must include at a minimum **one** example from the list below. • Document implementation of isolation, quarantine, movement restrictions, travel advisories, social distancing, closures, or other mitigation strategies the jurisdiction supported, coordinated, or led during the exercise or incident. See CAP11.1a-d. • Document how mitigation strategies were monitored during the exercise or incident CAP11.1a-d. • Document how partners were engaged to support mitigation strategies during the exercise or incident. See CAP11.2.	

Element	Data Entry Guidance	Significance
	Additional evidence for **Countermeasures and Mitigation** may include examples from the list below (**optional**). • Documentation that responder activity included information about potential hazards and risks. See CAP14.1a-c. • The health and safety of responders were monitored during the exercise or incident. See CAP14.1a-c. • Evidence that responders received PPE training and supplies during the exercise or incident. See CAP14.2a-b. • Documentation about responder activity including eligibility verification including screenings and countermeasures considerations. See CAP14.3a-c. **Evidence from the pandemic FSE exercise or incident might also meet criteria for additional five-year program requirements including the DSP FSE, DST FSE, and CWG FE** Select the associated five-year FSE program requirements to submit evidence that fully demonstrates Capability 8: Medical Countermeasure Dispensing and Administration or Capability 9: Medical Materiel Management and Distribution. • Select OPS2.m if the pandemic exercise or incident meets the criteria for **vaccinating CWG** during a pandemic. • Select OPS2.n or OPS2.o if the pandemic exercise or incident meets the criteria for **distribution or dispensing**, respectively. **PAN1.e** Evidence must illustrate the pandemic exercise or response reinforced the **Surge Management** domain by demonstrating the pandemic exercise or response reinforced **Capability 5: Fatality Management, Capability 7: Mass Care, Capability 10: Medical Surge,** or **Capability 15: Volunteer Management**. Evidence from the exercise or incident must include at a minimum **one** example from the list below. • Use of EDRS to share mortality information. See CAP5.1a • Issuance of death certificates or identification of interim sites for human storage. See CAP5.1b-d • Use of surveillance and mortality reporting to share information with partners. See CAP5.2a-c • Collection and dissemination of antemortem data to support victim identification or family notification. See CAP5.3a-c and CAP10.4. • Congregate site safety monitoring including food service, potable water, climate and waste management, and provision of health care services. See CAP7.1a-g • Accommodations for AFN populations in congregate settings. See CAP7.2. • Staffing surge to support clinical operations. See CAP10.1a-b.	

Element	Data Entry Guidance	Significance
	• Implementation of CSC. See CAP10.2. • Collaboration between public health and health care sectors. See CAP10.3a-f. • Evidence of volunteer management during the exercise or incident. See CAP15.1a-i. • Use of ESAR-VHP or equivalent system. See CAP15.2a-d. **PAN1.f** Evidence must illustrate the pandemic exercise or response reinforced the **Biosurveillance** domain by demonstrating the pandemic exercise or response reinforced **Capability 12: Public Health Laboratory Testing** and **Capability 13: Public Health Surveillance and Epidemiological Investigation** capabilities (examples of both are required). Evidence from the exercise or incident must include at a minimum **one** example from Public Health Laboratory Testing and **one** from Public Health Surveillance and Epidemiological Investigation. <u>Public Health Laboratory Testing</u> • Implementation of standard or novel detection methods given the pandemic scenario or incident. • Implementation of testing prioritization for the pandemic strain. • Use of novel collection methods like rapid test sites or drive-through facilities in communities, schools, workplaces, and healthcare settings. • Implementation of laboratory COOP or surge plans. • Rapid result reporting to stakeholders. <u>Public Health Surveillance and Epidemiological Investigation</u> • Case surveillance includes pertinent demographic, clinical, and epidemiologic characteristics for the pandemic disease. Reporting and dissemination of surveillance information to stakeholders. See CAP13.2 and CAP13.3a-b. Reporting and dissemination of epidemiological investigations to stakeholders. See CAP13.1a-d and CAP13.5a-b.	

Reviewer Guidance	Required Documentation	Submission frequency
Review evidence for the pandemic influenza FSE starting with data submitted about the exercise or incident. See Ops1a-j. At a minimum, substantive evidence with corresponding areas for improvement must be provided for each domain; that is, evidence must address each sub-element PAN1.a-e. However, the Biosurveillance domain (PAN1.f) requires two examples, one for Capability 12: Public Health Laboratory Testing and one for Capability 13: Public Health Surveillance and Epidemiological Investigation. **PAN1.a** Evidence must document inclusion of accommodations to address health equity for the whole population. If considerations for CMIST and whole population equity are not documented, this must be included as an area of improvement. **PAN1.b** At a minimum, the health department must be activated and have a substantial role in a pandemic response as one component of the pandemic FSE program requirement. See OPS1.j. Beyond documenting the public health role in the EOC activation, evidence must document scalable incident management principles for staffing and training (just-in-time for responders) consistent with NIMS principles. **PAN1.c** Evidence must document communication strategies for timely and accurate information flow were implemented during the exercise or incident. Emphasis on partner communications, particularly AFN partners, is required. **PAN1.d** Evidence must demonstrate how NPIs were exercised or applied in a pandemic response. Isolation and quarantine are enacted to prevent secondary exposure to people who have or may have a contagious disease. Isolation separates sick people with a quarantinable communicable disease from people who are not sick. Quarantine separates and restricts the movement of people who were exposed to a contagious disease to see if they become sick. See *Legal Authorities for Isolation and Quarantine*. Evidence must describe how isolation or quarantine was applied in the exercise or incident to meet the minimum intent of this measure.	At least one example of an implemented activity is **required** for each domain. Acceptable Evidence • AARs. • Call logs. • Corrective actions. • Drill summary sheets. • Meeting logs with partners identified. • Memos for the record. • Training plans with partner participation documented. Examples (not exhaustive) of acceptable documentation Evidence may overlap domains; associate with the domain best representative and notate any cross reference for the reviewer. **PAN1.a** Messages for whole community including AFN population that are written in simple language and large fonts; facility materials such as signage and handouts accommodate communication barriers such as language and literacy or photos documenting accommodations for persons with mobility issues. **PAN1.b** Incident action plans (IAP), ICS forms: CS Form 201, Incident Briefing (v3).pdf, CS Form 202, Incident Objectives (v3).pdf, ICS Form 203, Organization Assignment List (v3).pdf, ICS Form 209, Incident Status Summary (v3).pdf; noteworthy situation reports such as staffing or management updates, topical issues, or expedited contracts and resource procurement specific to supporting response objectives. **PAN1.c** JIC documents; HAN or equivalent communications; actual materials used during the exercise or incident; communications with K-12 schools, colleges and universities; communications with shared or congregate housing and long-term health care facilities; correctional institutions; tribal communities; older adults, or people with disabilities.	At minimum, submit once every five years.

Reviewer Guidance	Required Documentation	Submission frequency
Evidence documenting Capability 14: Responder Safety and Health must demonstrate protective actions for public health and other emergency responders during pre-deployment, deployment, and post-deployment and should address risk-specific training and monitoring given the nature of the pandemic exercise or response. Evidence from the pandemic FSE exercise or incident might also meet criteria for additional five-year program requirements including the DSP FSE, DST FSE, and CWG FE. See also DSP1-2, DST1a-j, and CWG1-3. **PAN1.e** Public health must identify and address potential shortages that require surge support during a pandemic. Evidence must describe surge management and illustrate how allocation decisions under conditions of extreme scarcity and urgent need was accomplished. Evidence must support maintenance of essential services and augmented emergency health care functions given an increased demand for supplementary staff and resources such as PPE due to the pandemic exercise or response. **PAN1.f** The Biosurveillance domain requires evidence for both Capability 12: Public Health Laboratory Testing and Capability 13: Public Health Surveillance and Epidemiological Investigation. Evidence must demonstrate continuity of laboratory services, including prioritization for processing samples related to the pandemic surge, and information exchange process among key public health and health care stakeholders. Evidence must also describe surveillance monitoring, reporting, investigations (contact tracing), and infection prevention and control protocols.	**PAN1.d** NPI toolkits, guidance (if adapted from CDC materials or developed by the jurisdiction), health department drive-through test sites (staffing, coordination, messaging); PPE allocations; ICS forms: ICS Form 208, Safety Message-Plan (v3).pdf, ICS Form 208HM, Site Safety and Control Plan (v3).pdf. **PAN1.e** Fatality management: evidence of coordination with the medical examiner/coroner (ME/C) for investigations or electronic death records; mass care evidence: shelter provisions for health screenings, coordination with homeless service providers, or mental/behavioral outreach or services; health care surge evidence: mobilization of medical surge personnel, activation of alternate care facilities, support for additional health care services, resources, or mutual aid such as augmenting requests for medicines, vaccines, ancillary supplies, ventilators, and PPE to health care facilities; volunteer evidence: management protocols that address recruitment, credentialing, deployment, and monitoring of safety and health. **PAN1.f** Biosurveillance evidence: pandemic protocols, expanded capacity, processing time; and protocols for contact tracing, surveillance reports, infection prevention and control; and examples of surveillance and epidemiological investigations for travel-associated exposures, homeless populations, or manufacturing facilities.	

PHEP-funded Laboratory Response Network for Biological Threats (LRN-B) Biological Sample Testing (LAB)

Element	Data Entry Guidance	Significance
LAB1 *PHEP-funded LRN-B biological sample testing.*	**LAB1** No data entry is required. Data are received directly from LRN-B. Proficiency test results are shown for PHEP-funded tests only. Review reported results from LRN-B for data accuracy of sample testing. Laboratory testing is associated with Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health: **Function 1:** Conduct laboratory testing and report results. **Task 1:** Check in samples for specimen testing. **Task 2:** Conduct specimen sample testing. **P1: (Priority)** LRN-B reference laboratories with proficiency in LRN-B testing methods and the ability to accurately test for agents.	Laboratory services must support the rapid detection of biological samples for the investigation and containment of hazards to the public's health. A laboratory must be deemed qualified to test for certain biological agents and then demonstrate ongoing proficiency of testing capabilities. The LRN proficiency testing (PT) challenge counts toward PHEP programmatic benchmark. Laboratory questions regarding the LRN PT and the PHEP benchmark, should be directed to the LRN Helpdesk.

Reviewer Guidance	Required Documentation	Submission Frequency
LAB1 Data about laboratory proficiency are received directly from LRN-B. Review uploaded data for accuracy. No more than one PHEP-funded LRN-B proficiency test can be unsuccessful. Failure to meet the benchmark must be documented as an area for improvement and might result in withholding of up to 10% of funding.	No documentation is required. Information is received directly from LRN-B.	Must be submitted annually.

PHEP-funded Laboratory Response Network for Chemical Threats (LRN-C) Chemical Sample Testing Using Core Methods; PHEP-funded LRN-C Chemical Sample Testing Using Additional Methods; and PHEP-funded LRN-C Specimen Packaging and Shipping Exercise (SPaSE) (LAB)

Element	Data Entry Guidance	Significance
LAB2.a-c *Ability of PHEP-funded LRN-C laboratories to successfully test chemical samples* *a. With core methods* (applicable to Level 1 and 2 laboratories; formerly performance measure 12.6), *b. With additional methods* (applicable to Level 1 laboratories, optional for Level 2 laboratories; formerly performance measure 12.5), and *c. Package and ship specimens properly* (applicable to Level 1, 2, and 3 laboratories specimen packaging and shipping exercise {SPaSE}, formerly performance measure 12.7).	**LAB2.a-c** No data entry is required. Data are received directly from LRN-C. LRN-C. Proficiency test results are shown for PHEP-funded tests only. Review reported results from LRN-C for data accuracy. Laboratory testing is associated with Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health: **Function 1:** Conduct laboratory testing and report results. **Task 1:** Check in samples for specimen testing. **Task 2:** Conduct specimen sample testing. **P2: (Priority)** LRN-C member laboratories with LRN-C Quality Assurance Program "qualified" status achieved through the successful participation in proficiency testing challenges. **Function 3:** Support training and outreach. **Task 2:** Maintain chain of custody procedures. **Task 3:** Support training, exercising, and laboratory participation in preparedness and response operations. **S/T2: (Priority)** Laboratory personnel certified in a shipping and packaging program that meets national and state or territorial requirements.	Laboratory services must support the rapid detection of chemical samples for the investigation and containment of hazards to the public's health. Successful demonstration of methods indicates ongoing proficiency of testing capabilities.

Reviewer Guidance	Required Documentation	Submission Frequency
Ten states have Level 1 laboratories: California, Florida, Massachusetts, Michigan, Minnesota, New Mexico, New York, South Carolina, Virginia, and Wisconsin. All other states, and L.A. County, New York City, and Washington, D.C. have Level 2 laboratories. Data about laboratory proficiency are received directly from LRN-C. Review uploaded data for accuracy. **LAB2.a** At least one LRN-C laboratory in the jurisdiction must participate in the exercise. **Core** method testing is applicable for both Level 1 and 2 LRN-C laboratories. However, only Level 1 laboratories must meet the 90% passing proficiency benchmark; at least one proficiency test must be passed for Level 2 laboratories. Failure to meet the benchmark must be documented as an area for improvement, and jurisdictions with Level 1 laboratories missing the benchmark might be subjected to a 10% withholding of PHEP funds. **LAB2.b.** At least one LRN-C laboratory in the jurisdiction must participate in the exercise. **Additional** methods are applicable for Level 1 laboratories (up to four additional methods) and optional for Level 2 laboratories (up to three additional methods). Likewise, only Level 1 laboratories must meet the 90% passing proficiency benchmark. Failure to meet the benchmark must be documented as an area for improvement and jurisdictions with laboratories missing the benchmark might be subjected to a 10% withholding of PHEP funds. **LAB2.c** Specimen packaging and shipping is applicable for all LRN-C laboratory levels. Evidence must document compliance with LRN-C standards for proper packaging and shipping of specimens. "Pass" indicates the laboratory met the 90% passing proficiency benchmark (90% of the SPaSE requirements were met). Jurisdictions with laboratory results of either "did not participate or did not pass" must document this as an area for improvement and might be subjected to a 10% withholding of PHEP funds for not meeting the benchmark.	No documentation is required. Information is received directly from LRN-C.	Must be submitted annually.

PHEP 24/7 Emergency Contact Drill (BIDIRECTIONAL)

Element	Data Entry Guidance	Significance
LAB3. *PHEP 24/7 Emergency Contact Drill (Bidirectional).*	**LAB3** No data entry is required. Information is received from CDC's EOC staff, whom initiate the drill. Start time is defined as the date and time that CDC EOC staff first dialed the contact number for the on-call laboratorian or epidemiologist, depending on drill direction. Stop time is defined as the date and time that the on-call laboratorian or epidemiologist, depending on drill direction, contacted CDC EOC to complete the drill cycle. The performance target is 45 minutes or less, the difference between start and stop time. Review reported results for data accuracy to conduct rapid communication between a jurisdiction's on-call epidemiologist and on-call laboratorian. The bidirectional drill is associated with Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health: **Function 2:** Enhance laboratory communications and coordination. **Task 2:** Coordinate with preparedness partners to support public health investigations. **P4:** Updated contact list for LRN-B laboratories (sentinel and public health laboratories), LRN-C laboratories, and in the jurisdiction as well as other jurisdictional laboratories that collaborate with the public health agency.	A timely and effective response to incidents of public health significance requires the ability to rapidly communicate critical information for situational awareness. The bidirectional 24/7 emergency contact drill tests the ability for rapid communication between a jurisdiction's on-call epidemiologist and on-call laboratorian. This is a PHEP requirement supported by the CDC EOC.

Reviewer Guidance	Required Documentation	Submission Frequency
LAB3 Review reported results for data accuracy to conduct rapid communication between a jurisdiction's on-call epidemiologist and on-call laboratorian. Failure to successfully complete the drill within 45 minutes must be documented as an area for improvement. See CCS to crosswalk accuracy of contact information.	No documentation is required. Information is completed by CDC's EOC. Optional Evidence • Contact information for the on-call laboratorian and on-call epidemiologist if different than CCS.	Must be submitted annually.